CITY OF EUGENE

January 1, 2005

To Our Employees:

This handbook is designed to inform you about your health, life, long-term disability insurance and other benefits provided by the City of Eugene. With this information, you will be able to take advantage of these important benefits.

This handbook is a summary of your benefits in force as of January 1, 2005, and is not a contract. The legal documents which govern in all cases and set forth the plans in full are available at Human Resource and Risk Services. Any of the benefits provided under the plans may be changed, replaced or terminated by the City of Eugene and the affected bargaining units at any time.

It is our hope that this handbook will help you use your benefits wisely.

Sincerely,

Dennis M. Taylor
City Manager

City of Eugene

Employee Benefits Handbook

City Health Plan Medical, Dental, & Vision Insurance
Employee Assistance Program
Flexible Spending Account Program
Life and Long-term Disability Insurance

Revised January 2005

This edition of the City of Eugene Employee Benefits Handbook is for employees who are in the following employee groups: AFSCME, EPEA, Non–Represented, IAFF and IATSE. This summary supersedes all previous benefit handbooks distributed to employees with City Health Plan medical-dental-vision coverage.

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HEALTH PLAN INTRODUCTION

At the City of Eugene, you have a health care program designed to provide you and your dependents with financial assistance toward maintaining your good health. The City Health Plan is self-funded and consists of medical, dental, and vision coverage administered by ODS Health Plan, Inc.

This plan helps pay your medical expenses, hospitalization costs, and doctors' fees. It also helps pay the cost of dental care, from routine examinations to orthodontic treatment.

For your good health, the City Health Plan is designed to:

- Protect employees and their families against catastrophic loss;
- Give employees the maximum health benefits from available financial resources; and
- Promote the health and well-being of employees and their families, and reduce the impact of sudden illness.

COVERAGE QUESTIONS

Medical or Vision: 877-605-3229 or by email: medical@odscompanies.com
Dental: 877-277-7280 or by email: dental@odscompanies.com
Pharmacy: 888-361-1610
Mental Health & Chemical Dependency: 800-799-9391

Refer to your Group Plan Number:

M056 — Medical
N222 — Vision
2796 — Dental

Send **Medical or Vision** claims to:

ODS Health Plan, Inc.
PO Box 40384
Portland OR 97240-0384

Send **Dental** claims to:

ODS Health Plan, Inc.
601 SW Second Avenue
Portland OR 97204

SUMMARY OF MEDICAL BENEFITS

This is only a brief summary of your medical benefits. Please refer to the additional information provided in this handbook for an explanation of your benefits including limitations and exclusions.

GENERAL INFORMATION

Benefit Description	City Health Plan Coverage Administered by ODS Health Plan, Inc.
Eligibility	Regular full-time and part-time employees scheduled to work at least 20 hours per week (or who otherwise qualify as regular part-time employees under an applicable labor agreement or administrative policy). IATSE-represented employee eligibility specified in most recent labor agreement between IATSE and the City of Eugene. "Limited Duration Employees" and "Benefitted Temporary Recreation (BTR) Employees" as defined in the current AFSCME labor agreement may elect non-contributory medical, dental and vision coverage for the employee or may add dependents at the employee's expense.
When Coverage Begins	First of the month following date of hire (following date of eligibility for IATSE-represented employees and AFSCME-represented BTR employees).
Benefit Levels	The City Health Plan uses the ODS Network Preferred Provider Organization (PPO). Benefit levels for most services after the deductible: • In-Network provider: 80% • Non-Network provider: 50%
Choice of Physician/Hospital	Any qualified physician. You must go to a network physician or hospital to receive network benefits inside the service area.
Service Area	Includes all Oregon counties. Also Pacific, Wahkiakum, Cowlitz, Clark, Skamania, Klickitat, Benton, Walla Walla Counties in Washington state. And Washington, Valley, Payette, Gem, Canyon, Boise, Ada, Elmore, Owhyee, and Twin Falls Counties in Idaho.
Required Premiums	Certain groups of employees may be required to contribute toward the cost of coverage under the plan. If you are a member of one of these groups, you will be provided information regarding the applicable premium costs from Human Resource and Risk Services (HRRS).
Calendar Year Deductible per Person	$100 (Non-represented group $150 per person; AFSCME $125 per person)
Calendar Year Deductible per Family	$300 (Non-represented group $450 per family; AFSCME $375 per family)

Benefit Description	City Health Plan Coverage Administered by ODS Health Plan, Inc.
Lifetime maximum Benefit per Person	$2,000,000
Calendar Year Out-of-Pocket Maximum Expense per Person	For EPEA and IATSE groups: $850 For AFSCME group: $925; increases to $975 on January 1, 2006 For Non-represented group: $1,150 For IAFF group: $950 (amounts include the deductible)
Deductible Carryover	If eligible expenses incurred in October, November, or December are used to meet the current year's deductible, they will be carried forward and applied to the next year's deductible (applies to individual deductible only).
Annual Benefit Restoration	Automatic benefit restoration equal to the actual amount of benefits used up to a maximum of $2,000 every 12 months.

PHYSICIAN SERVICES

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Accidental Injuries	80%, no deductible	50%, no deductible
Allergy Injections	80% after deductible	50% after deductible
Hospital Visits	80% after deductible	50% after deductible
Maternity Care (including prenatal, delivery, postnatal care of mother and infant)	80% after deductible (must be insured at time of delivery)	50% after deductible (must be insured at time of delivery)
Office Visits	80% after deductible	50% after deductible
Surgery/Inpatient	80% after deductible	50% after deductible
Surgery/Outpatient	100%, no deductible	50%, no deductible

PREVENTATIVE AND WELL CARE SERVICES

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Cancer Screening, including Breast, Pap, Pelvic, and Colonoscopies (subject to exam frequency limits.)	80%, no deductible	50%, no deductible
Immunizations	Children under two: 80%, no deductible; covered only under Well Baby/Child Care Adults and children age two and over: 80%, no deductible (benefit does not apply to EPEA employees and retirees)	Children under two: 50%, no deductible; covered only under Well Baby/Child Care Adults and children age two and over: 50%, no deductible (benefit does not apply to EPEA employees and retirees)

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Physical Exams (age two and over, subject to exam frequency limits.)	80% to maximum of $250 per exam, no deductible	50% to maximum of $250 per exam, no deductible
Well Baby/Child Care From birth to age 12 months 13 months to age 24 months up to a maximum of two visits	80%, no deductible 80%, no deductible	50%, no deductible 50%, no deductible

SPECIAL PROVISIONS

BENEFIT	
Mental and Nervous Condition (Maximum benefit each 24 months)	Covered same as any other illness; subject to deductible. See Medical Coverage section for specific limitations**.**
Chemical Dependency, Drug Dependency, and Alcoholism (Maximum benefit each 24 months)	Covered same as any other illness; subject to deductible. See Medical Coverage section for specific limitations**.**

HOSPITAL INPATIENT SERVICE

Inpatient services subject to compliance with utilization review procedure

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Room and Board		
Non-Intensive Care Unit Benefit Maximum (benefit maximum may be adjusted annually if necessary)	80% after deductible up to $891 average per day semi-private room rate for IATSE groups (per day maximum waived for AFSCME-, EPEA-, IAFF-represented and Non-represented employees and retirees)	50% after deductible up to $891 average per day semi-private room rate for IATSE groups (per day maximum waived for AFSCME-, EPEA-, IAFF-represented and Non-represented employees and retirees)
Intensive Care Unit Benefit Maximum (benefit maximum may be adjusted annually if necessary)	80% after deductible up to $2,674 average per day (three times average daily semi-private room and board rate) for IATSE groups (per day maximum waived for AFSCME-, EPEA-, IAFF-represented and Non-represented employees and retirees)	50% after deductible up to $2,674 average per day (three times average daily semi-private room and board rate) for IATSE groups (per day maximum waived for AFSCME-, EPEA-, IAFF-represented and Non-represented employees and retirees)

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Neonatal Intensive Care Unit Benefit Maximum (benefit maximum may be adjusted annually if necessary)	80% after deductible up to $3,140 average per day for IATSE groups (per day maximum waived for AFSCME-, EPEA-, IAFF-represented and Non-represented employees and retirees)	50% after deductible up to $3,140 average per day for IATSE groups (per day maximum waived for AFSCME-, EPEA-, IAFF-represented and Non-represented employees and retirees)
Extended Care Facility (60-day maximum benefit period per calendar year)	50% after deductible for daily room and board; services other than room and board paid at benefit level applicable to the service performed	50% after deductible for daily room and board; services other than room and board paid at benefit level applicable to the service performed
Additional Inpatient Hospital Expenses	80% after deductible	50% after deductible

HOSPITAL OUTPATIENT SERVICES

BENEFIT		
Ambulance	80% for medically necessary ambulance transportation after the deductible for service to and from the nearest hospital that can give necessary care and treatment. (Covered at 100% with no deductible for IAFF-represented employees)	
Medical Emergency Care for an Illness	80% after deductible	
Medical Emergency Care for an Injury	80% with no deductible	
Facility Charges	Preferred Provider: 100% after deductible (80% after deductible for Non-represented, AFSCME- and IAFF-represented employees and retirees)	Non-Preferred Provider: 50% after deductible for non-represented and IAFF-represented employees and retirees (50%, no deductible for AFSCME-represented employees and retirees)

PRESCRIPTION DRUG COVERAGE

(See Medical Coverage section for details)
ODS Health Plans Retail Pharmacy Network and
Walgreens Healthcare Plus Mail Order Pharmacy

BENEFIT	Non-Represented
Retail Pharmacy Generic: Preferred Brand: Premium Brand:	Co-payment (paid after deductible) 10% or $10, whichever is greater 20% or $15, whichever is greater 25% or $25, whichever is greater
Mail-Order Purchases Generic: Preferred Brand: Premium Brand:	Co-payment 10% or $10, whichever is greater 20% or $15, whichever is greater 25% or $25, whichever is greater

BENEFIT	EPEA & IATSE Groups
Retail Pharmacy Generic: Brand Name:	Co-payment (paid after deductible) $10 20%
Mail-Order Purchases Generic: Preferred Brand: Premium Brand:	Co-payment $10 $20 25% or $25, whichever is greater, up to $50 maximum

BENEFIT	IAFF Group
Retail Pharmacy Generic: Brand Name:	Co-payment (paid after deductible) $10 20%
Mail-Order Purchases Generic: Preferred Brand: Premium Brand:	Co-payment $10 $20 or 20% ,whichever is greater, up to $25 maximum 25% or $25, whichever is greater, up to $60 maximum

BENEFIT	AFSCME Group
Retail Pharmacy Generic: Brand Name: Premium Brand:	Co-payment (paid after deductible) $10 20% 25%
Mail-Order Purchases Generic: Preferred Brand: Premium Brand:	Co-payment $10 $20 25% or $25, whichever is greater, up to $60 maximum

ADDITIONAL SERVICES

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Acupuncture	80% after deductible for acupuncture services performed by registered acupuncturist or physician	
Alternate Care Benefits	Services of licensed massage therapists, consultations with registered dieticians, office visits to licensed naturopaths paid at 80% after deductible (benefit does not apply to EPEA group). Benefits are limited as follows:	
	Maximum benefits paid per calendar year as follows: Licensed massage therapists — $300; Naturopaths — $300; Dietician services — $200 (No limit on number of medically necessary visits)	
Chiropractic Treatment	80% after deductible, limited to 52 visits per calendar year.	
Diabetic Instruction	80% after deductible	50% after deductible
Diagnostic X-ray and Lab Services	80% after deductible when prescribed by a physician in case of illness	50% after deductible when prescribed by a physician in case of illness
Hearing Aids (benefit does not apply to EPEA employees and retirees)	50% of eligible expenses after deductible, up to a $500 maximum benefit ($1000 maximum benefit for AFSCME Group) during a 36-month period	

BENEFIT	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Hearing Analysis	80% after deductible if prescribed by physician when medically necessary	
Home Health Care (includes professional nursing services; health aid services from licensed/accredited programs)	100% after deductible; limited to 100 4-hour visits per calendar year	80% after deductible; limited to 100 4-hour visits per calendar year
Hospice Care (inpatient or outpatient services, professional nursing services from licensed and accredited programs) Bereavement Counseling	100% after deductible for terminally ill patients with a life expectancy of up to six months $25 per visit for a maximum of 12 visits per calendar year	
Midwifery/Birthing Centers (Free Standing Centers)	100% after deductible	50% after deductible
Occupational and Speech Therapy	80% after deductible	
Physical Therapy	80% after deductible if prescribed by a physician	
Prosthetic Devices	80% after deductible for devices replacing bodily functions	
Radiotherapy	80% after deductible	50% after deductible
Rehabilitation (In-patient)	80% after deductible	50% after deductible
Transplantations	80% after deductible, subject to exclusions and limitations)	50% after deductible, subject exclusions and limitations
Tubal Ligation and Vasectomy (Reversals are not covered)	80% after deductible	50% after deductible

SUMMARY OF DENTAL BENEFITS

This is only a brief summary of your dental benefits. Please refer to the additional information provided in the Dental Coverage section of this handbook for details.

The City Health Plan utilizes the ODS dental plan. ODS has contracted with participating dentists and has approved their fee schedules. As a result, your share of the dental costs may be reduced. Benefit levels for non-participating providers are based on the prevailing fee level charged by other dentists for the same services.

BENEFIT	
Calendar Year Deductible	For Non-represented, AFSCME-, IAFF-, and IATSE-represented groups: $50 per person; $150 family maximum For EPEA-represented group: $25 per person; $75 family maximum
Maximum Dental Benefit	For Non-represented, EPEA-, and IATSE-represented: $250 per person for expenses incurred first calendar year of eligibility; $1,250 per person each calendar year thereafter For AFSCME-represented: $250 per person for expenses incurred first calendar year of eligibility; $1,400 per person each calendar year thereafter For IAFF-represented: $300 per person for expenses incurred first calendar year of eligibility; $1,300 per person each calendar year thereafter
Preventative Services Exams, Bitewing X-rays, Fluoride, Cleaning	100% -- no deductible
Basic Services Fillings, Crowns, Denture Repairs	80% -- after deductible
Major Services Initial Dentures and Bridgework	50% -- after deductible
Orthodontic Services (Pre-treatment estimate required)	50% -- no deductible $2,000 per person maximum lifetime benefit

SUMMARY OF VISION BENEFITS

This is only a brief summary of your vision benefits. See the Vision Coverage section of this handbook for additional information about your benefits.

BENEFIT	Non-Represented, EPEA & IATSE	IAFF	AFSCME
Deductible	None		
Covered Vision Services	Exams, lenses and frames, contact lenses, medically necessary subnormal vision aids		
Eye Exams (once every 12 months)	80% up to $60	80% up to $75	80% up to $60
Lenses (per lens)***			
Single Vision	$20	$25	$25
Bifocal	$30	$40	$40
Trifocal	$40	$40	$40
Lenticular	$60	$60	$60
Frames*** (one pair, once every 24 months)	$50	$60	$60
Contacts*** (per lens, once every 24 months)			
After cataract surgery	$60	$75	$60
To correct extreme visual acuity problems (20/70)	$60	$75	$60
Cosmetic Contacts (both lenses)	$70	$90	$90

***Plan members are eligible for prescription lenses and frames **OR** prescription contacts every 24 consecutive months if prescription changes.

ODS PROVIDER NETWORK

ODS NETWORK – PREFERRED PROVIDER ORGANIZATION (PPO)

The City Health Plan includes a Preferred Provider Organization (PPO) through ODS Health Plan, Inc. The ODS PPO used by the City Health Plan includes health care providers in all Oregon counties. The PPO is an important feature of the City Health Plan, consisting of a network of physicians, podiatrists, and hospitals that provide health care at negotiated discounted rates. These discounts are passed on to plan participants and the City. Use of a PPO provider benefits both you and the City as we work together to manage health care costs.

The City Health Plan gives you the freedom to choose any physician, podiatrist, or hospital at the point in time you need care. You may choose to see a PPO provider and, in most cases, receive higher benefit levels, or you may see a provider that is not part of the PPO and receive lower benefit levels. You make the choice each time you receive medical care covered by the plan.

ACCESSING THE PPO

You may choose any of the ODS PPO providers and facilities at the time you need service. You do not need to select a primary care physician and you do not need referrals in order to access specialists. For more information about the network physicians, contact ODS at 877-605-3229. A provider directory will be automatically provided to you without charge. For additional information regarding the list of providers, contact Human Resource and Risk Services (HRRS). You can also find up-to-date PPO listings on the ODS website (www.odscompanies.com). Click on the "ODS Network."

CONTINUITY OF PPO CARE RATES

Continuity of PPO care rates means the feature of the plan that allows a covered person who is receiving care from a preferred provider to continue to receive care from the provider on a PPO coverage basis for a limited period of time after the provider's PPO medical services contract with the claims administrator has terminated.

Continuity of PPO care rates is conditioned upon the willingness of the provider to adhere to the medical services contract that had most recently been in effect between the provider and the claims administrator, and the acceptance by the provider of the contractual reimbursement rate applicable to the time of contract termination (or if the contractual reimbursement rate was not based on a fee for service, a rate equivalent to the contractual rate).

In order for a covered person to be eligible for continuity of PPO care rates, all of the following conditions must be satisfied:

- The covered person must request continuity of PPO care rates from the claims administrator;
- The covered person must be undergoing an active course of treatment that is medically necessary and, by agreement of the provider and the claims administrator, it is desirable for the covered person to maintain continuity of care with the provider; and
- The contractual relationship between the provider and the claims administrator with respect to the plan has ended.

The claims administrator will not be required to make continuity of PPO care rates available when the contractual relationship between the provider and the claims administrator ceases by reason of one of the following circumstances:

- The provider:
  - Has retired;
  - Has died;
  - No longer holds an active license;
  - Has relocated out of the service area;
  - Has gone on sabbatical; or
  - Is prevented from continuing to care for patients because of other circumstances; or
- The contractual relationship has terminated in accordance with provisions of the medical services contract relating to quality of care and all contractual appeal rights of the provider have been exhausted.

Except in the case of pregnancy, a covered person who is entitled to continuity of PPO care rates will be eligible for such PPO coverage rates until the earlier of the following dates:

- The day following the date on which the active course of treatment entitling the covered person to continuity of PPO care rates is completed; or
- The 120th day after the date of notification by the claims administrator to the covered person of the termination of the contractual relationship with the provider.

A covered person who is undergoing care for pregnancy and who becomes entitled to continuity of PPO care rates after commencement of the second trimester of the pregnancy will be eligible to receive the care on a PPO coverage basis until the later of the following dates:

- The 45th day after the birth; or
- As long as the covered person continues under an active course of treatment, but not later than the 120th day after the date of notification by the claims administrator to the covered person of the termination of the contractual relationship with the provider.

PPO BENEFIT LEVELS

Benefit levels listed in this booklet assume plan participants receive services through the ODS PPO network, when applicable. After the deductible, the City Health Plan will pay most covered physician and hospital services in the following manner:

- In-network providers: 80%
- Non-network providers: 50%

PPO EXCEPTIONS

Benefits will be paid at the in-network level (80% of maximum plan allowance charges, in most cases) for services provided by chiropractors, psychologists, acupuncturists, optometrists, and other eligible non-physician providers.

If there is no PPO provider who can provide a covered service, or if you are out of the service area and cannot see a PPO provider, benefits will be paid at the in-network level (80% of maximum plan allowance charges, in most cases).

COVERAGE OUTSIDE THE SERVICE AREA FOR DEPENDENT CHILDREN

During the period that a covered dependent child under the applicable age limit as specified by the plan resides outside the service area, the dependent child will receive benefits for treatment of an illness or injury, and preventive health care and maternity services, as if the care were rendered by a preferred provider, subject to the following limitations:

- Fees charged by out-of-area professional providers will be reimbursed at the maximum plan allowance for those services; and
- Benefits and co-payments apply as if the patient had been referred to a preferred provider.

EMERGENCY MEDICAL CARE

You are covered for treatment of medical emergencies worldwide. Emergency medical care rendered by non-preferred providers will be reimbursed at the preferred provider rate. However, benefits are subject to the plan's contracted rates for preferred providers and the maximum plan allowance for non-preferred providers. Any emergency room co-payments in effect are deducted at that time, along with any co-payments that may apply to the type of service received. If a covered hospitalization immediately follows emergency services, the emergency room co-payments will be waived. All other applicable co-payments remain in effect.

Prior authorization is not required for emergency medical screening exams, stabilization of an emergency medical condition (meaning a medical condition that manifests itself by symptoms of sufficient severity, including severe pain), or when emergency services are provided by a non-preferred provider if a prudent layperson possessing an average knowledge of health and medicine would reasonably believe that the time required to go to a preferred provider would place the health of the person, or a fetus in the case of a pregnant woman, in serious jeopardy.

If the patient's condition requires hospitalization in a non-preferred provider facility, the attending physician and the claims administrator's medical director will monitor the confinement and will determine when the transfer to a preferred provider facility can be made. The plan does not provide preferred provider-level benefits for care beyond the date the attending physician and medical director determine the patient can be safely transferred.

Preferred provider benefits will not be available if a covered person goes to a non-preferred provider for care other than emergency medical care. The following are not considered emergency services and are not eligible for preferred provider-level benefits:

- Routine adult physical examinations, women's examinations, well-baby and child care, immunizations or eye examinations;
- Diagnostic work-ups for chronic conditions; and
- Elective surgery and/or hospitalization unless preauthorized as services not readily accessible from preferred providers.

HEALTH PLAN ELIGIBILITY

All regular full-time and part-time or Limited Duration employees scheduled to work at least one half the available hours in the pay period (or who otherwise qualify as regular part-time employees under an applicable labor agreement or administrative policy) are eligible for the medical, dental, and vision plan. Eligibility for IATSE-represented members is specified in the most recent labor agreement between IATSE and the City of Eugene. Eligibility for AFSCME-represented Benefitted Temporary Recreation (BTR) employees is specified in the most recent labor agreement between AFSCME and the City of Eugene.

In addition, compensated elected officials (the Mayor and City Councilors) are eligible for coverage on a self-pay basis. In order to qualify for coverage, the elected official must elect to participate in the plan and pay the required premiums. Compensated elected officials are eligible for the same coverage under the plan as Non-represented employees.

WHEN COVERAGE BEGINS

Your medical, dental, and vision coverage begins on the first of the month following your date of hire. For IATSE-represented employees or AFSCME-represented BTR employees, coverage begins on the first of the month following your date of eligibility. If you are not actively at work on the date coverage would begin, other than by reason of a medical condition, your coverage will begin when you resume employment.

PAYROLL DEDUCTIONS

Certain groups of employees may be required to contribute toward the cost of health insurance coverage. The contribution is in the form of a Payroll Deduction for a portion of the health insurance premium. Premiums may change annually, and generally increase each year.

For full-time employees, the payroll deduction for health insurance premium is based on single, two-party or family enrollment and the plan selected. For part-time employees, the deduction is based on enrollment tier, the plan selected and the number of hours you are scheduled to work. Non-represented employees may "opt-out" of City-provided health insurance (medical, dental, and vision) coverage, with *proof of other coverage*. The proof (in the form of a copy of wallet ID from another insurance carrier, or similar documentation) must be attached to the "Opt-out" form.

Contact Human Resource and Risk Services (HRRS) for more information.

WHEN COVERAGE ENDS

Your medical, dental, and vision coverage will end on the earliest of the following dates:

- The date you are no longer eligible for coverage under the plan;
- The date the plan terminates; or
- The end of the month for which you paid the last required premium.

Medical, dental, and vision coverage for your eligible dependents also ends when your coverage stops or, if earlier, as of the date your dependent children no longer qualify for coverage because of their age or marital status.

Note: Employees who pay a portion of their health insurance premium through a payroll deduction should promptly notify HRRS when any covered dependent no longer qualifies for health insurance coverage to ensure that the correct payroll deduction is taken.

LEAVE OF ABSENCE

Your coverage and that of your covered dependents will be continued while you are on paid leave of absence. Coverage will ordinarily terminate on the last day of the month in which the paid leave ends. If you are granted a leave of absence *without pay*, you can continue your health insurance coverage on a self-pay basis as described below.

When your coverage (or coverage for a dependent) ends, you may continue your health care coverage on a self-pay basis if certain qualifying events occur. Thereafter, you may be eligible to secure major medical coverage through Oregon Medical Insurance Pool. Refer to Continuing Your Coverage section for more information.

YOUR DEPENDENTS' COVERAGE

As an employee eligible for medical, dental, and vision coverage, you can cover your eligible dependents. Eligible dependents include:

- Your legal spouse;
- Your unmarried dependent children under age 19;
- Any other of your unmarried children under 19 if you are legally required to contribute towards their support;
- Your unmarried dependent children who are full-time students at least 19 and under 23 years of age. The age limit for a student-dependent of an EPEA employee is age 25. Under IRS rules, if the student-dependent is older than age 23 as of the last day of a calendar year, the value of the student-dependent's coverage may be included in the employer's gross income unless the employee provides more than one-half of the student-dependent's support for the year;

- For IATSE-represented employees: A newborn child born to a covered dependent is eligible for coverage for the first 31 days following the grandchild's birth; and
- Any unmarried child who had been covered as a dependent and who continues to be your dependent because of a physical or mental disability regardless of age. However, the disability must have existed before the child's 19th birthday.

The following are considered your children:

- Your natural child, including a child born out of wedlock for whom you are financially responsible;
- Your adopted child or a stepchild, including situations where there is a Qualified Medical Child Support Order (QMCSO) that requires your spouse to provide health insurance coverage;
- Children placed with you for adoption (placement for adoption means you have assumed and retained a legal obligation for full or partial support of the child in anticipation of adoption);
- Children related to you by blood or marriage (including a grandchild) for whom you are the legal guardian (you will need to provide a court order showing legal guardianship); and
- Children for whom you have obtained and provided to the City a Decree of Parental Rights (for Non-represented employees and retirees only).

TIMING OF ENROLLMENT

If you are required to contribute toward either employee or dependent coverage, the employee and the dependent must enroll within the first 31 days following the date of initial eligibility in order to qualify for coverage.

An employee or dependent who does not enroll within 31 days of initial eligibility for contributory coverage must wait until the next open enrollment to enroll, except in the case of a newly acquired dependent or a loss of coverage situation for which special enrollment rules under the plan will apply.

An individual will not have to wait for the next open enrollment in any of the following situations:

- The individual qualifies for special enrollment under either of the special enrollment provisions described below.
- A court has ordered that coverage be provided for the spouse or dependent child of an employee under the plan and a request for enrollment is made within 30 days after issuance of the court order; or
- The individual's coverage under Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan, has been involuntarily terminated within 63 days of applying for coverage under the plan.

SPECIAL ENROLLMENT OF NEWLY ACQUIRED DEPENDENTS

If you get married while you are covered under the City Health Plan, your spouse and his or her children become immediately eligible for coverage. A newborn or adopted child, or a child placed with you for adoption, also become immediately eligible for coverage. Upon the event of a newborn or adopted child, your spouse, if not then already covered, is also immediately eligible for coverage.

Your newborn or adopted child will be covered for:

- Injuries;
- Sickness;
- Birth defects;
- Well baby care; and
- Premature birth.

You must enroll newly acquired dependents within 31 days following their initial eligibility. If you do not enroll your dependents within 31 days of eligibility, you will have to wait until the next open enrollment period to cover them under the health plan.

SPECIAL ENROLLMENT UPON LOSS OF OTHER HEALTH COVERAGE

If you declined coverage under the City Health Plan because you were covered under another group health plan or insurance policy, or if you declined coverage for a dependent who was then covered under another group health plan or insurance policy and if that coverage is later terminated, you or your dependent, as the case may be, may then be eligible for immediate coverage under the City Health Plan.

In order to be eligible for this special enrollment, the other health coverage that had been in effect when coverage under the City Health Plan was declined must have been either:

- COBRA continuation coverage under a group health plan that had subsequently been exhausted; or
- Another form of health coverage that was terminated by reason of a loss of eligibility for coverage, or because employer contributions toward the other coverage had been discontinued.

You or your dependent are not eligible for special enrollment under the City Health Plan if the loss of eligibility for coverage under another group health plan is due to the failure to pay premiums for such coverage on a timely basis, or if the termination of coverage was for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

You must enroll yourself or your dependent, as the case may be, within 31 days of the loss of the other coverage. In addition, you must then provide to ODS Health Plan Inc., a certificate of creditable coverage or other documentation evidencing that other health coverage for you or your

dependent, as relevant, was in effect when the prior coverage was declined and the date of the subsequent loss of that coverage.

Coverage will become effective on the first day of the calendar month beginning after the date the request for enrollment. However, this coverage will be conditioned upon the prompt provision of a certificate of creditable coverage or other acceptable documentation of prior coverage.

OPEN ENROLLMENT

The City of Eugene has annual open enrollment each May or June. This is generally the only time during the year that you may change from the City Health Plan to another health plan offered by the City. In addition, you may at that time add eligible dependents who were not previously enrolled under the plan. All changes become effective July 1. Some employee groups may have special enrollment criteria specified in union contracts, for example, regular IATSE-represented employees; AFSCME-represented Limited Duration and Benefitted Temporary Recreation employees.

Employees who change employee units during the year, or who change from part-time to full-time status (or visa versa), may elect to change health plans or add eligible dependents within 31 days of the change in employment status.

ELIGIBLE DOMESTIC PARTNERS

The domestic partner of a regular City employee is eligible for coverage under the City Health Plan, provided that the employee and domestic partner meet the eligibility requirements prescribed in this section and submit an "Declaration of Domestic Partnership" to the Human Resource and Risk Services (HRRS).

Eligibility

The domestic partner of a regular City employee is eligible for coverage under the City Health Plan only if the domestic partner and the employee have met all the criteria below for at least 12 months:

- Are each 18 years of age or older;
- Are not legally married to anyone;
- Are each other's sole domestic partner living together in a spousal equivalent relationship;
- Have shared the same regular permanent residence for at least twelve (12) months immediately preceding the date of the Declaration of Domestic Partnership and represent in such Declaration an intent to continue to do so indefinitely;
- Are financially interdependent and jointly responsible for "basic living expenses"; and
- Are not related by blood so close as to bar marriage in the State of Oregon and are mentally competent to consent to a contract.

"Basic living expenses" means the cost of basic food, shelter and other expenses. The employee and domestic partner need not contribute equally or jointly to the costs of these expenses as long as they agree that both are responsible for the cost.

Upon request, an employee must provide HRRS with documents establishing that a person enrolled under the plan as a domestic partner meets the eligibility criteria set forth above. If the employee does not produce documentation within thirty (30) calendar days of the request, the domestic partner coverage may be retroactively rescinded. The employee may further be required to reimburse the City or the plan for any expenditures made on behalf of the ineligible domestic partner, including, but not limited to, premiums, medical claims, administrative charges and attorneys' fees.

Enrollment

An eligible domestic partner and the legal dependents of the domestic partner can be enrolled in the City Health Plan, subject to the terms and conditions set forth below.

- A domestic partner can be enrolled within the same time periods that apply to the enrollment of spouses under the plan, including:
  - during the first thirty-one (31) days of eligibility following the domestic partner's initial eligibility for coverage; and
  - during an annual open enrollment period.
- If a domestic partner is enrolled in the health plan, then the children of the domestic partner who otherwise meet the eligibility criteria for dependent coverage under the health plan can be enrolled within the same time periods that generally apply under the health plan with respect to the enrollment of dependents.
- Except as provided below, domestic partners and their dependents are eligible under the health plan for the same benefits under the same conditions as provided to spouses and dependents of married employees within the same employer group.
- Coverage is effective on the date the Declaration of Domestic Partnership is executed.

Additional Conditions

The City Health Plan's coverage of domestic partners and their dependents is subject to the following additional terms and conditions:

- Domestic partners and their dependents are eligible for continued coverage under either the COBRA or the retired employee continuation coverage provisions of the health plan.
- Upon termination of the domestic partner relationship, or if the domestic partner no longer meets the criteria for plan coverage, the employee must submit a "Statement of Termination of Domestic Partnership" to HRRS within thirty (30) calendar days of the event. After such termination of coverage, the employee may not enroll a new domestic partner under the health plan within twelve (12) months after the date a Statement of Termination of Domestic Partnership was submitted.

- Any employee enrolling a domestic partner and, if applicable, the dependents of a domestic partner under the plan will be responsible for the same premium contribution towards the cost of dependent coverage as imposed upon married employees within the same employer group having dependent coverage.
- An employee enrolling a domestic partner under the health plan will not be eligible to pay for the cost of coverage under the plan (including for the coverage of the employee and any dependents of the employee) on a before-tax basis under the City of Eugene Flexible Spending Account (FSA) program unless the employee advises HRRS that the domestic partner qualifies as a dependent of the employee under applicable IRS rules by submitting an "Declaration of Dependent Status". Accordingly, all premium contributions required to be paid by such employee under the plan must be made on an after-tax basis.
- Under IRS rules, the plan's coverage of a domestic partner who is not a qualified dependent is a taxable benefit to the employee. In such circumstances, employees must pay income taxes on the fair market value of the health plan coverage provided to their domestic partners. The value of the domestic partner coverage is considered wages, is included in the employee's gross income, and is subject to state and federal income tax and FICA withholding.
- The value of the coverage of a domestic partner who qualifies as a dependent of the employee under the IRS rules will not be subject to taxation, and thus will not be included in the employee's wages. The employee may also pay for the cost of the coverage of the domestic partner on a before-tax basis under the City's FSA program. In order for the coverage to be eligible for this favorable tax treatment, the employee must submit an Declaration of Dependent Status to HRRS.

Upon request, an employee must provide to HRRS a new Declaration of Dependent Status, and such other documents establishing the domestic partner's status as a dependent of the employee. If the employee does not provide such documents within thirty (30) calendar days of the request, the value of the coverage of the domestic partner under the plan will become taxable to the employee as provided in the preceding paragraph.

GENERAL INFORMATION

ODS HOSPITAL REVIEW PROGRAM

Pre-Authorization of Hospital Admissions Required

ODS Health Plan, Inc. provides hospital utilization review services for you and your dependents. The process is simple and is done completely by phone. No forms are required. All you need to do is call their toll free number, 877-605-3229, within five days of any non-emergency hospital admission.

ODS will consult with your attending physician to:

- Confirm the hospitalization is medically necessary;
- Preauthorize a normal hospital length of stay based upon the medical condition; and
- Recommend alternative health care services, if appropriate.

Emergency Admissions

Prior authorization is not required for hospital admissions for emergency medical conditions. For this purpose, an "emergency medical condition" is a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

Even though prior authorization is not required for emergency admissions, ODS must be contacted within 48 hours of the admission (or as soon as reasonably possible). The call can be made by you, a family member, your doctor, or the hospital.

Benefit Reductions for Non-Compliance

To receive the maximum benefits under the City Health Plan, you must comply with the ODS review program. A benefits reduction of 20% (but not more than $2,500) will apply to all hospital admissions and lengths of stay which exceed the authorized duration.

BONUS CASH AWARD PROGRAM

As a smart health care consumer, you should check for errors in your medical bills. Many mistakes are ones only you are aware of. Check these items:

- Duplicate Charges – Does your bill indicate too many charges for the same service?
- Room and Board – Are the charges for the actual number of nights you spent in the hospital?
- Type of Room – Are the charges for a private room when you stayed in a semi-private room?
- Medications – Were you charged for drugs or medications that you didn't receive?
- Diagnostic/Laboratory Charges – Were the tests you were billed for actually completed?

The Bonus Cash Award program awards you for finding errors in your (or your dependents') bills from a hospital, physician or other professional provider. These errors reduce the total expenses paid by the health plan. If you believe you were incorrectly charged:

- Call the hospital, or the office of the physician or professional provider, as applicable, and report the overcharge. Request a revised bill.
- Send both the original bill and revised bill to Human Resource and Risk Services.

The error must be acknowledged by ODS and the City of Eugene. A check for 50% of the plan savings, up to a maximum of $500, will then be issued to you.

CONSENT TO EXAMINATION OF MEDICAL RECORDS

By acceptance of the benefits provided under the City Health Plan, you and your dependents are deemed to have consented to the examination of medical records by the claims administrator, or its designee, for the purpose of utilization review, quality assurance and peer review.

CONFIDENTIALITY OF INFORMATION

ODS has developed a policy and procedures to protect the confidentiality of medical records and other information regarding covered plan members. With certain limited exceptions, Oregon law requires health plans to obtain a written authorization from the enrollee or his or her representative before disclosing personal information.

MONITORING OF COMMUNICATIONS

ODS reserves the right to monitor telephone conversations and e-mail communications between its employees and its customers for legitimate business purposes as determined by ODS. The monitoring is to ensure the quality and accuracy of the service provided by employees of ODS.

LANGUAGE ASSISTANCE

Non-English speaking enrollees can request assistance from one of ODS's multi-lingual customer service representatives. ODS also utilizes AT&T language service interpreters.

AMENDMENT OR TERMINATION OF PLAN

The City of Eugene intends to continue to maintain the City Health Plan indefinitely. However, subject to any collective bargaining requirements, the City reserves the right at any time and from time to time to amend or terminate in whole or in part any of the provisions of the plan or any of the benefits provided under the plan. Any such amendment or termination may take effect retroactively or otherwise. In the event of a termination or reduction of benefits under the plan, the plan will be liable only for benefit payments due and owing as of the effective date of such termination or reduction, and no payments scheduled to be made on or after such effective date will result in any liability to the plan or the City of Eugene. If in the future any provision of the City Health Plan is materially modified, you will be provided timely written notice of the modification.

IMPORTANT TERMS

The following terms have special meaning as they relate to your medical plan. Other terms are defined where they are first used in this booklet.

MEDICALLY NECESSARY

Medically necessary means those services and supplies that are required for diagnosis or treatment of illness or injury and which, in the judgment of the ODS, are:

- Consistent with the symptoms or diagnosis and treatment of the covered person's condition;
- Appropriate with regard to standards of good medical practice;
- Not primarily for the convenience of the covered person or provider of services or supplies;
- Not primarily custodial care; and
- The least costly of the alternative supplies or levels of service that can be safely provided to the covered person.

This means, for example, that care rendered in a hospital inpatient setting or by a nurse in the patient's home is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility, without harm to the patient.

The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply medically necessary.

PRIOR AUTHORIZATION

Prior authorization, also known as preauthorization, is the process ODS uses to determine the medical necessity of a service before it is rendered. Examples of some of the services that require preauthorization include:

- Cosmetic procedures (to determine medical necessity),
- Elective surgical procedures,
- Infusion therapy,
- Transplant procedures,
- Circumcision beyond three-months of age,
- Dental services related to TMJ,
- Some durable medical equipment and supplies, and
- Diagnostic procedures (including Colonoscopy with family history diagnosis).

Contact the ODS Medical Customer Service Department at 800-575-9295 for a detailed list of services that should be preauthorized, or for questions on specific services.

Many types of treatment may be available for certain conditions; the preauthorization process helps your physician work together with you, other providers, and ODS to determine the treatment that best meets your medical needs and to avoid duplication of services. An approved preauthorization is your assurance that insurance benefits won't be denied because they don't meet the definition of "medical necessity."

SCOPE OF PRIOR AUTHORIZATION

Except in the case of fraud or misrepresentation, prior authorization for the coverage of a particular benefit and medical necessity shall be binding under the plan if obtained no more than 30 days prior to the date the service is provided. Subject to the same exception, prior authorization in regard to an individual's status as a covered person shall be binding if obtained no more than five business days prior to the date the service is provided.

EXPERIMENTAL OR INVESTIGATIONAL

Experimental or investigational means any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, at the time of service, does *not* meet the following criteria:

- Approval has been granted by the Federal Food and Drug Administration (FDA), or by another United States government agency, for general public use for treatment of a condition; and
- Treatment is rendered by an institution or provider within the United States that has scientifically demonstrated proficiency in such treatment; and
- The treatment is accepted as a standard of practice by the Medical Community and by the specialty it involves.

Drugs that have not already been approved by the FDA are considered to be investigational and experimental. There may be instances where an FDA approved drug is used for other than the condition it has been approved for. In such instances the use of the approved drug may be considered to be investigational or experimental.

PRE-EXISTING CONDITIONS

A pre-existing condition is any condition for which medical advice, diagnosis, care or treatment was recommended by, or received from, a professional provider during the 90-day period before your (or your dependent's) coverage eligibility date.

If you receive treatment for a pre-existing condition after your coverage becomes effective, your medical coverage for that condition is limited to $2,000. This limitation applies during the first 6 months from your date of eligibility for medical coverage under the City Health Plan. However, this 6-month limitation period is reduced for the period that you or your dependent had medical coverage in effect under another medical plan or insurance policy immediately prior to your eligibility for coverage under the City Health Plan. Thus, if the period of that prior coverage exceeded 6 months, the pre-existing condition limitation will not apply.

If you or your dependent had prior coverage, your former employer or insurance company will provide you with a certificate evidencing that coverage. You should submit this certificate upon enrollment in the plan, or, if later, when the certificate is provided to you. If your former employer or insurance company has not provided you with this certificate of coverage (or if you have misplaced it), you have the right to request the certificate from the former employer or insurance company. If necessary, we will assist you in obtaining this certificate.

The pre-existing condition limit will not be applied with respect to:

- Any pregnancy-related pre-existing condition;
- Genetic information in the absence of a diagnosis of a condition related to such information;
- A newborn child who, as of the last day of the 30-day period beginning on the date of birth, had creditable coverage in effect; or
- A child who is adopted or placed for adoption before attaining age 18, and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, had creditable coverage in effect.

This exemption from the pre-existing condition limitation for a newborn or adopted child no longer applies after the child incurs a significant break in coverage.

QUALIFIED MEDICAL PROFESSIONALS

The following list of medical professionals, providing service within their lawful scope of practice, are covered by the medical plan:

- Doctor of Medicine (M.D.);
- Doctor of Osteopathy (D.O.);
- Chiropractor;
- Podiatrist;
- Licensed Midwife or Nurse Midwife;
- Licensed Dentist (Doctor of Medical Dentistry or Doctor of Dental Surgery), but only for the following dental services:
    - Treatment of accidental injury to natural teeth or a fractured jaw, including replacement of injured natural teeth, so long as treatment is provided within six months of the accident;
    - Surgical removal of impacted teeth; or
    - Surgical treatment of the mouth or gums that does not involve repair, removal, or replacement of teeth;
- Licensed Psychologist;
- Licensed Psychologist Associate-Resident;
- Licensed Clinical Social Worker (M.S.W.), but only for services rendered upon the written referral of a Doctor of Medicine or Osteopathy, or a Psychologist;
- Registered Acupuncturist;
- Certified Nurse Practitioner;

- Physician Assistant;
- Registered Physical, Occupational, Speech or Audiological Therapist, an individual who is licensed to perform audiometric examinations and dispense hearing aids (Audiologist), or Certified Speech Pathologist, but only for rehabilitative or diagnostic testing services rendered upon the written referral of a Doctor of Medicine or Osteopathy;
- Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), but only for services rendered upon the written referral of a Doctor of Medicine or Osteopathy, and only for those services nurses customarily provide to patients;
- Licensed Naturopath, Licensed Massage Therapist, Registered Dietician; and
- Licensed Pharmacist.

MAXIMUM PLAN ALLOWANCE

The Maximum Plan Allowance for medical benefits is the maximum amount which the plan will reimburse professional providers. For a preferred provider, the maximum amount is the contracted fee. For non-preferred providers, the maximum amount is the lesser of supplemental provider fee arrangements or the seventy-fifth (75^{th}) percentile of fees commonly charged for a given procedure in a given area, based on the Ingenix MDR System, a national database. If this database does not contain a fee for a particular procedure in a particular area, the claim is referred to ODS's medical consultant, who will determine a comparable code to the one billed. ODS will use the maximum plan allowance for the comparable code to price the claim.

The Maximum Plan Allowance for Prescription Drug benefits is the maximum amount which ODS will reimburse professional providers for medications. For a preferred provider, the maximum amount is the contracted fee. For a non-preferred provider, the maximum amount is no more than the prevailing pharmacy network fee based on Average Wholesale Price determined by First Data Bank, minus a percentage discount.

MAXIMUM PLAN ALLOWANCE - DENTAL COVERAGE

This plan will pay providers the Maximum Plan Allowance for the treatment or service according to the schedule of benefits in effect on the date such treatment or service is provided to the covered person. Maximum Plan Allowance means:

- The accepted filed fee for a participating dentist; or
- The prevailing fee for a non-participating dentist.

Non-participating dentists have the right to balance bill the difference between the maximum plan allowance and the actual charge.

MEDICAL COVERAGE

ABOUT THE DEDUCTIBLE

The deductible is the amount you and your eligible dependents must pay for covered medical expenses each calendar year (January 1 through December 31) before the plan will pay benefits for any additional covered expenses you incur that year. See the Summary of Medical Benefits for the deductible amounts for each employee group.

No more than three deductibles must be paid by any one family per calendar year, and only one deductible is required if two or more family members incur medical expenses as a result of the same accident.

Current employees transferring from the Managed Care plan to the City Health Plan during the annual open enrollment period will be given a $50 ($75 for Non-represented group members) credit toward the first calendar year deductible. Each family member will also receive a $50 ($75 for Non-represented group members) credit up to a $150 ($225 for Non-represented group members) family maximum in the first calendar year.

CARRY-OVER DEDUCTIBLE

The deductible must be satisfied each year. However, medical expenses incurred in October, November, or December which are used to meet the current year's deductible will be applied toward the individual's deductible for the next year.

For example, if your deductible is $150, $65 in covered medical expenses is applied toward your deductible in December, you will need only $85 in eligible charges to meet the next year's deductible ($65 + $85 = $150 annual deductible).

MEDICAL BENEFITS ONCE YOU MEET THE DEDUCTIBLE

After you meet the deductible, the plan will pay 80% of most eligible medical expenses each calendar year. You pay the other 20% plus the deductible, up to your out of pocket maximum. After that, the plan pays 100% of eligible expenses in that calendar year. See the Summary of Medical Benefits for details.

LIFETIME MAXIMUM

The maximum lifetime benefit is $2,000,000. However, if you are covered for 12 consecutive months and receive benefits, the actual amount of benefits paid, up to a maximum of $2,000, is restored each calendar year.

COVERED MEDICAL EXPENSES

You and your eligible dependents have a complete package of health care services and protection for illness, injury, and certain preventive care. The plan covers the services and supplies listed below. However, with the exception of preventative and well care services, the services and supplies must be medically necessary as determined by ODS. For amounts paid by the plan, refer to the Summary of Medical Benefits section.

ACCIDENTAL INJURIES

No deductible is required for covered expenses incurred due to an accident.

ACUPUNCTURE

Covered after the deductible for acupuncture services performed by a registered acupuncturist or physician.

ALTERNATE CARE

(EPEA-represented employees and retirees not eligible for this benefit)

Medically necessary services of licensed massage therapists, consultations with registered dieticians (in addition to the Diabetic Instruction benefit under the plan), and office visits to licensed naturopaths, covered after deductible.

For AFSCME, IAFF, IATSE, & Non-represented Groups, benefits limited as follows:

- Licensed massage therapists — $300 per calendar year, no limit on the number of visits;
- Naturopaths — $300 per calendar year, no limit on the number of visits;
- Dietician services — $200 per calendar year; no limit on the number of visits.

AMBULANCE SERVICE

Medically necessary ambulance transportation to the nearest facility that has the capability to provide the necessary treatment. Benefits will be paid to you and the provider, or directly to the provider.

CHEMICAL DEPENDENCY / MENTAL AND NERVOUS CONDITIONS

The following definitions apply only for the plan's benefits provided for treatment of chemical dependency (including alcoholism) and mental illness:

- "Chemical Dependency" means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes

with the person's social, psychological or physical adjustment to common problems on a recurring basis. Chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods;

- "Child or Adolescent" means a person who is 17 years of age or younger;
- “Dual Diagnosis” means a condition involving both a mental illness and chemical dependency which requires treatment of the simultaneous conditions and is such that one condition could not be treated independent of the other.
- "Inpatient Care" means care provided in an inpatient psychiatric or chemical dependency treatment facility, hospital or other facility accredited by the Joint Commission on Accreditation of Hospitals, which provides full-day or part-day acute treatment of alcoholism, drug addiction, or mental illness and is licensed to admit patients who require 24-hour-a-day skilled nursing care;
- "Outpatient Care" means diagnosis or treatment of a person who is not an inpatient of a health facility or participating in a residential facility program. Outpatient service must be provided as part of a program approved by the Oregon Mental Health Division or the Oregon Department of Human Resources Office of Alcohol and Drug Abuse Programs (or the equivalent agency if services are provided outside of Oregon), or by one of the following:
  - A physician;
  - A psychologist;
  - A nurse practitioner;
  - A registered clinical social worker upon the written referral of a physician or psychologist;
  - A health facility; or
  - A residential facility.
- “Residential Care” means care provided in a Residential Facility.
- "Residential Facility" means a program or facility approved by the Oregon Mental Health Division or the Oregon Office of Alcohol and Drug Abuse Programs (or equivalent agency as explained above) or accredited by the Joint Commission on Accreditation of Hospitals, which provides an organized full-day or part-day program of treatment for alcoholism, drug addiction, or mental illness, but is not licensed to admit patients who require 24-hour-a-day skilled nursing care.

Covered expenses for treatment of chemical dependency and/or mental illness are limited, in all cases, to services and supplies (including medications) which are provided in the least costly treatment setting which, in ODS’s judgment is medically appropriate for the individual patient's condition.

If services are provided in a treatment setting, which in ODS’s judgment is inappropriately, benefits will be limited to the amount that would have been paid if those services had been provided in the least costly treatment setting appropriate to provide that care.

Benefits for the treatment of chemical dependency and for the treatment of mental or nervous conditions are in the aggregate subject to the limits set forth below in a single 24 consecutive month period.

	Mental Health or Mental Health/Chemical Dependency Combined			Chemical Dependency	
	Children	Adults		Children	Adults
Inpatient	15 days	14 days		19 days	14 days
Residential	19 days	19 days		24 days	19 days
Outpatient	29 visits	29 visits		42 visits	32 visits

A single 24 consecutive month benefit period begins with the first date of treatment for a mental health and/or chemical dependency condition. Benefits will renew in full on the first day of the 25th month following the initial use of treatment. For purposes of the above, "children" means covered persons 17 years of age or younger.

If, during a 24-consecutive-month period a covered person receives covered services and supplies for a combined diagnosis of both chemical dependency and mental illness, benefits will be calculated on the basis that such services and supplies were for the treatment of mental illness alone. Benefits in a 24-month period for both mental illness and a combined diagnosis of chemical dependency and mental illness will not exceed the maximum days or visits for mental illness alone.

In addition to the exclusions listed in the Medical Expenses Not Covered section, the plan will not pay for the following services:

- Educational programs for drinking drivers;
- Voluntary mutual support groups, such as Alcoholics Anonymous; and
- Family education or support groups.

CHIROPRACTIC CARE

Routine treatment includes initial exam, x-rays, manipulation and therapy performed by a chiropractor or other qualified medical professional, subject to limitations. Chiropractic visits are limited to a maximum of 39 over a nine consecutive month period.

DENTAL CARE

Certain dental procedures are covered under this medical plan:

- Treatment for an accidental injury in which the jaw is broken or the natural teeth are injured, provided that the treatment occurs within six months of the injury;
- Surgical removal of impacted teeth; and
- Other surgical treatment of the mouth or jaw that does not involve the repair, removal or replacement of teeth.

DIABETIC INSTRUCTION

The plan will cover diabetes self-management programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes prescribed by a health care professional legally authorized to prescribe such programs. The plan will cover one diabetes self-management program of assessment and training after diagnosis and subsequently no more than three hours per year of assessment and training upon a material change of condition, medication or treatment that is:

- An education program credentialed or accredited by a state or national entity accrediting such programs; or

- Provided by a physician, a registered nurse, a nurse practitioner, a certified diabetes educator or a licensed dietitian with demonstrated expertise in diabetes.

EMERGENCY SERVICES

The plan pays after the deductible for medical emergency care for an illness. No deductible applies for medical emergency care for an accidental injury.

HOME HEALTH CARE

The plan pays covered expenses when services are provided by an R.N., L.P.N. or registered physical therapist and prescribed by a physician. Care should be provided in place of hospital services or admission. Your physician must give approval every three months for continuing home health care.

This benefit is limited to 100 four-hour home health care visits per calendar year. Twenty-four-hour care or private duty nursing is not covered.

HOSPICE CARE

Hospice care refers to specific treatment for the terminally ill (a life expectancy of less than six months) and their family members. The plan covers hospice benefits only if the covered person's physician orders and approves the services before the services begin. Services must be provided by either a hospital, hospice, or a licensed health service agency.

Covered hospice expenses include:

- Daily hospice room and board;
- Services and supplies furnished by a hospice;
- Homemaker services;
- Health aid services consisting of patient care by home health aid or health aid agency representative;

- Professional nursing services for part-time intermittent professional nursing services charged by an R.N. or L.P.N.;
- Bereavement counseling provided to members of the terminally ill individual's family. The counseling must take place between the date hospice care expenses begin and within six months after the terminally ill individual has died. This benefit is limited to 12 visits per calendar year, and a maximum of $25 per visit.

HOSPITAL INPATIENT SERVICES

(Subject to compliance with Utilization Review)

Hospital room and board benefits are based on the rate for a semi-private room as shown in the Summary of Medical Benefits section, along with intensive care and neonatal intensive care room rates. These allowances are adjusted annually, if necessary.

Additional hospital services, including x-ray, radiotherapy, laboratory services, prescription medication, cardiac care, and operating room are covered expenses under the plan.

HOSPITAL OUTPATIENT SERVICES

This plan pays benefits for hospital outpatient services under the following conditions only:

- The covered expenses must be for surgery because of illness or the treatment of an accidental injury.
- The treatment or service must be provided in:
    - A hospital outpatient department;
    - A neighborhood health center;
    - A clinic; or
    - An outpatient surgical facility.

Hospital outpatient services include the following covered expenses:

- Ambulance Transportation. Medically necessary ambulance transportation to and from the nearest hospital that can give necessary care and treatment.
- Emergency Medical Care. Emergency medical care and additional outpatient hospital expenses for treatment of illness or accidental injury. Elective surgical procedures are not covered expenses as emergency medical care.
- Outpatient Surgery. Outpatient surgery expenses for treatment, services or supplies received by a covered person on an outpatient basis. (Physician services paid at 100%, no deductible required.)
- Additional hospital outpatient services includes the following:
    - Administration of anesthetics by a physician or a registered nurse anesthetist (R.N.A.);
    - Services of radiologists and pathologists who are under contract with the hospital to provide their services;
    - Diagnostic X-ray and laboratory services;
    - Radiotherapy;

- Prescription medication;
- Cardiac care;
- Operating room charges; and
- Surgery facility charges.

Expenses incurred during an overnight hospital confinement are not covered expenses under this hospital outpatient services provision.

INFUSION THERAPY

The plan covers infusion therapy services and supplies as described below, when required for administration of an infusion therapy regimen. The services must be ordered by a physician and must be medically necessary. **Preauthorization of infusion services is required.**

Home infusion therapy must be provided by an accredited home infusion therapy agency. In addition to the above requirements, the patient receiving the services must qualify as being "homebound." Infusion therapy is limited to the following:

- Aerosolized pentamidine;
- Intravenous drug therapy;
- Total parenteral nutrition;
- Hydration therapy;
- Intravenous/subcutaneous pain management;
- Terbutaline infusion therapy;
- SynchroMed pump management;
- IV bolus/push drugs; and
- Blood product administration.

Additionally, covered expenses include only the following medically necessary services and supplies:

- Solutions, medications and pharmaceutical additives;
- Pharmacy compounding and dispensing services;
- Durable medical equipment for the infusion therapy;
- Ancillary medical supplies;
- Nursing services associated with:
  - Patient and/or alternative care giver training;
  - Visits necessary to monitor intravenous therapy regimen;
  - Emergency services;
  - Administration of therapy; and
- Collection, analysis and reporting of the results of laboratory testing services required to monitor response to therapy.

MATERNITY CARE

Hospital services including prematurely interrupted pregnancies and caesarean sections are covered the same as any other medical condition. Maternity Care means regular obstetrical care, including delivery and cesarean section, for a covered employee, the covered spouse of an employee, or a covered dependent child of an employee. This includes prenatal, delivery and postnatal care of mother and infant, including routine nursery care for a newborn infant for the same number of days the mother is hospital confined.

Covered expenses also include delivery at a licensed, free-standing, birthing center and physician services including prenatal, delivery and postnatal care of mother and child.

In compliance with federal law, the plan does not restrict benefits for a mother's or a newborn child's hospital stay in connection with a childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, such federal law does not prohibit the mother's or newborn child's attending professional provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, the plan may not require a provider to obtain authorization from the plan for prescribing a length of stay of up to the 48 (or 96) hour minimum.

MENTAL AND NERVOUS CONDITIONS

For the benefits for the treatment of mental and nervous conditions provided by the plan, refer to the Chemical Dependency/Mental and Nervous Conditions section.

PHYSICIAN SERVICES

Fees for the following physician services are covered under the plan:

Accidental Injuries
- Allergy Injections
- Hospital Visits
- Maternity Care
- Office Visits
- Surgery--Inpatient and Outpatient

PRESCRIPTION DRUG PROGRAM

See the Summary of Medical Benefits for the schedule of benefits and co-payment information.

ODS Health Plan, Inc. - Retail Pharmacy Network

The City Health Plan uses the ODS retail pharmacy network. The ODS pharmacy network provides discounts when you purchase drugs at participating pharmacies. The City of Eugene has developed this program to save money for both you and the City Health Plan.

In order to access the ODS discounts you must show the pharmacy your ODS wallet ID card each time you have a prescription filled. Here are the steps to follow:

- Verify your pharmacy is currently participating with ODS Health Plan, Inc. Pharmacy Network by contacting the pharmacy, or by checking the ODS provider directories on the ODS Health Plan, Inc. web page at www.odscompanies.com. If they are not participating, have your pharmacy contact ODS Pharmacy Claims at 1-888-361-1610.
- Present your ODS Identification Card to your participating pharmacy so they can properly process your prescriptions and calculate your prescription discounts.
- Pay 100% of the discounted rate for your prescription at the pharmacy. Attach your prescription receipts to a claim form and mail them to ODS for the appropriate reimbursement.

Prior Authorization

Some prescription drugs require prior authorization before you can access the ODS Pharmacy Network discounts. Prior authorization is required in certain instances to determine medical necessity and to make sure that newly FDA approved drugs are used appropriately. In addition, all prescriptions over $500 require prior authorization. If you have questions about prescription drug prior authorization, call ODS.

There are no penalties if you use a non-participating pharmacy, but you will end up paying more for your prescription because you will not have the advantage of the ODS negotiated pharmacy discounts.

Specialty Drugs

Certain prescription drugs, including most self-injectables and infusion drugs, may be purchased through the ODS Specialty Pharmacy Provider. In addition, these drugs may require prior authorization by ODS.

Walgreens Healthcare Plus - Mail Order Pharmacy

The Walgreens Healthcare Plus mail order prescription drug program is in addition to the City Health Plan prescription drug coverage. For those who regularly take one or more types of prescription drugs, this program provides a convenient way to have your drugs delivered directly to your home.

The mail order pharmacy co-payment cannot be reimbursed through the City Health Plan and it does not apply to your deductible or out of pocket maximums; however, if you have elected to participate in the Flexible Spending Account (FSA) Program, the co-payment can be reimbursed from your FSA Health Care Account. The plan's eligibility requirements, pre-existing condition limitations, and other limitations and exclusions apply to the Walgreens Healthcare Plus program.

Generic drugs will be substituted for brand-name drugs when available and allowed by the prescribing physician. Walgreens Healthcare Plus substitutes only the highest rated generic drugs available.

For more information, call Walgreens Healthcare Plus customer service at 1-800-635-3070 between 7:00 a.m. and 5:00 p.m., Monday through Friday. Order forms are available from Human Resource and Risk Services.

Definitions: Generic, Preferred and Premium Brand Name Drugs

- *Generic* drugs are those determined to be therapeutically equivalent to the brand name version and are equally safe and effective. By law, both brand name and generic drugs must meet the same standards for safety, purity, strength and quality. Generic drugs are usually much less expensive than the brand name drug.
- *Preferred brand* drugs are those determined by ODS to be equally safe and effective as premium brand drugs at favorable costs.
- *Premium brand* drugs are those determined by ODS to be equally safe and effective as preferred brand drugs but are more costly.

Contraceptive Drugs and Devices

The City Health Plan will provide benefits for oral birth control pills and other contraceptive drugs and devices that cannot legally be dispensed without a prescription, and that by law must bear the legend "Caution-Federal law prohibits dispensing without prescription." Oral birth control pills and contraceptive drugs and devices purchased at the pharmacy will be covered under the pharmacy benefit of the plan. Prescribed contraceptive drugs and devices received in a doctor's office will be covered under the plan as a supply.

PREVENTATIVE AND WELL CARE SERVICES

- Cancer screenings:
    - Routine colonoscopies are covered once every 10 years starting at age 50;

- Other cancer screenings including but not limited to Pap smears, pelvic examinations and proctosigmoidoscopies are covered once every 12 months, except that the following are covered at any time upon the referral of the patient's health care provider:
    - Pelvic and Pap smear examinations; and
    - Mammograms performed for the purpose of diagnosis in symptomatic or high-risk women.

- Immunizations for children under two years old are covered under well baby care.

- Immunizations for adults and children over two years old (EPEA employees and retirees not covered for this benefit) are covered (influenza virus, polio, measles, rubella, whooping cough, diphtheria, tetanus and mumps). Immunizations for employment, licensing, passports, and travel are not covered.
- Physical Exams - Frequency of covered physical exams is based on age:

0 - 2 Years	Covered under well baby care
2 - 17	Every three years
18 - 40	Every five years
41 - 64	Every three years
65+	Every year

- Well Baby/Child Care - Routine checkups and immunizations, injections and inoculations are covered during the first 24 months of life. Between 13 months and 24 months of age, there is a maximum of 2 visits.

TRANSPLANTATIONS

The plan will pay benefits for organ and other transplantations on the same basis as for any other illness, subject to the conditions, exclusions and limitations prescribed below. The following definitions apply to the transplantation coverage provisions of the plan.

- "Transplantation" means:
    - A procedure or a series of procedures by which tissue (i.e., solid organ, marrow, stem cells) is removed from the body of one person (donor) and implanted in the body of another person (recipient); or
    - A procedure or series of procedures by which tissue is removed from one's body and later reintroduced back into the body of the same person.

For purposes of the plan's coverage of transplantations, the term "transplantation" does not include the collection of and/or transfusion of blood or blood products. The term also does not include corneal transplants.

- "Donor costs" means the cost of medical services required to remove the tissue from the donor or self-donor's body, and to preserve or transport the tissue to the site where the transplantation is performed.

Expenses incurred by a donor who is a covered person which result from complications and unforeseen effects of the donation will be covered under the plan on the same basis as any other illness.

Transplantation services are eligible covered expenses only for medically necessary transplantation procedures which are recognized as conforming to generally accepted medical practice and which, in the judgment of ODS, do not constitute experimental or investigational treatment.

The treatment of transplantation procedures as a covered expense under this plan is subject to the additional exclusions and limitations prescribed below.

- If the recipient and the donor are *both* covered persons under this plan, transplantation-related expenses will be covered for both the recipient and the donor.
- If the donor is covered under this plan and the recipient is not, the plan will not pay any benefits toward donor costs. Complications and unforeseen effects of the donation will be covered on the same basis as any other illness.
- If the recipient (including a self-donor) is a covered person under this plan, the plan will pay donor costs up to a maximum of $15,000 per covered transplant.
- The plan will cover a maximum of $2,500 per covered transplant, up to a limit of $250 per day, for reasonable and necessary living and transportation expenses for the covered person and one companion.

ADDITIONAL SERVICES

The following services are additional covered expenses under the plan (if the benefit level is not indicated below, see the Summary of Medical Benefits section for amounts paid under the plan):

- Blood and Plasma are covered 80% after the deductible, unless replaced for the patient.
- Casts, Splints, Braces, and Crutches are covered 80% after the deductible when prescribed by a physician.
- Elemental Enteral Formula ordered by a physician for home use is covered 80% after the deductible.
- Extended Care Facility benefits are paid as hospital benefits for a maximum of 60 days per calendar year, so long as care begins within 14 days after a hospital confinement of at least three days.
- False Limbs, Contact Lens to Replace Lens of Eye, Initial Breast Implant after Surgery are covered 80% after the deductible.
- Hearing Aids (Benefit does not apply to EPEA employees and retirees).
- Hearing Analysis if prescribed by a physician when medically necessary.
- Metabolism Treatment is covered 80% after the deductible. Coverage is for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist. Coverage includes diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.
- Midwifery and Licensed Birthing Center charges.

- Oxygen and Rental of Oxygen Equipment are covered 80% after the deductible.
- Podiatry is covered at 80% after the deductible.
- Maxillofacial Prosthetic Services are covered at 80% after the deductible. These services are defined as those considered necessary for adjunctive treatment, which means restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of:
    - Controlling or eliminating infection;
    - Controlling or eliminating pain; or
    - Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.
- Reconstructive Surgery (Non-Cosmetic). Cosmetic surgery is surgery that improves or changes appearance without restoring impaired body function. Reconstructive surgery is surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is usually performed to improve function, but may also be done to approximate a normal appearance.
- Cosmetic surgery is not covered under the plan. However, reconstructive procedures which are partially cosmetic in nature may be covered if ODS medical director finds the procedure to be medically necessary. All reconstructive procedures must be preauthorized and medically necessary approved or benefits will not be paid.
- Complications related to a surgery performed to correct a functional disorder will be covered when determined medically necessary.
- Nasal rhinoplasty is cosmetic surgery and is not covered.
- Breast augmentation and breast asymmetry or prosthetics deemed to be too large or too small have no bearing on restoration of function. These surgeries are considered cosmetic and are not covered. (For exceptions, see "reconstructive surgery following a mastectomy" below.)
- Coverage for surgery performed to reduce breast size (breast reduction) is subject to a finding of being medical necessary and must be preauthorized.
- Coverage is also available for the following services if preauthorization indicates it is medically necessary.
    - Surgical repair of congenital cosmetic deformities;
    - Hormone related conditions, as the covered person's situation develops; and
    - Any form of acne surgery, including cryotherapy, dermabrasion, and excision of acne scarring, and found to be medically necessary by a physician review.
- Reconstructive surgery following a mastectomy (in a manner determined in consultation with the attending physician and the patient) as follows:
    - All stages of reconstruction of the breast on which the mastectomy has been performed, including but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola;
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
    - Prostheses;
    - Treatment of physical complications of the mastectomy, including lymphedemas; and
    - Inpatient care related to the mastectomy and post-mastectomy services.

The patient's physician must contact ODS to receive authorization in advance. Coverage at the Surgery/Inpatient or Surgery/Outpatient (as applicable) rates as set forth in the Summary of Medical Benefits.

- Rental of Medical Equipment (Wheelchair, Hospital Bed, Durable Medical Equipment) when prescribed by a physician is covered at 80% after the deductible up to the purchase price of the rental equipment.
- Surgical Bandages are covered at 80% after the deductible.
- Tubal Ligation and Vasectomy (reversals are not covered).
- Diagnostic x-ray, lab tests, and radiation therapy.
- Occupational and Speech Therapy for services provided by a registered therapist for therapeutic treatment, if prescribed by a physician for a medically necessary condition.
- Rehabilitation (Physical Therapy) for services rendered upon the written referral of a physician for a medically necessary condition.
- Services and supplies for the treatment of morbid obesity will be covered when authorized as medically necessary by ODS.

MEDICAL EXPENSES NOT COVERED

Charges for the following services and supplies are *not* Covered Medical Expenses under the plan:

- Services, procedures, supplies and drugs constituting experimental or investigational treatment as determined by ODS;
- Services or supplies that are provided free of charge, or for which the charges are waived;
- Charges that exceed the maximum plan allowance;
- Custodial care;
- Routine physical examinations primarily for insurance, licensing, employment and non-preventive purposes or other medical examinations or tests not connected with the care and treatment of an actual illness or injury except as specifically provided in the schedule of medical benefits section of this plan. Any charges for medical records necessary to determine benefits. School physicals occurring more often than scheduled preventive benefits;
- Prescriptions not required for treatment of a specific illness or injury (unless expressly covered under the plan);
- Treatment that is not considered medically necessary except for preventive care as specified by the plan;
- Treatment of an illness or injury for which you are covered under Workers' Compensation or similar State or Federal programs, except services provided by a Veterans Hospital for non-service related illnesses or injuries;
- Treatment for an injury caused by a fight in which you were an aggressor;
- Treatment for an injury to you while committing, or attempting to commit, a felony;
- Any illness or injury as a result of war or an act of war or which occurs while you are in active military service status for any country and covered under the plan;
- Services provided under any government-sponsored medical or health plan, except as coordinated with Medicare;

- Eye refractions; orthoptics; visual therapy; or providing; replacing; or fitting glasses (such services are covered under the covered Vision expenses portion of this plan);
- Dental treatment or dental x-rays (such services are covered under the covered Dental expenses section of this plan);
- Weak, unstable, or flat feet or bunions, except an open cutting operation on the foot or orthotic appliances supplied by a podiatrist;
- Radial keratotomy, eximer laser retroactive surgery, and similar surgical procedures to correct nearsightedness;
- Cosmetic procedures (i.e., any procedure that is requested for the purpose of improving appearance without restoring bodily function or correcting physical impairment) are exclusions under this plan except for cosmetic surgery required as a result of an accidental injury or for a birth defect or illness of a covered dependent child born to a covered person. Complications of reconstructive surgeries will be covered if medically necessary, clinically distinct and not specifically excluded under this plan. Breast augmentation, lipectomy, liposuction, hair removal (including electrolysis and laser) and rhinoplasty are not covered procedures;
- Services or supplies related to sex change operations, sexual dysfunction or sexual inadequacy;
- In vitro fertilization or artificial insemination; or GIFT;
- Reversal of sterilization procedures;
- Treatment of corns, calluses or toenails, except when a portion of the nail root is removed;
- Illness or injury that occurs while you are on active military service for any country while covered under this plan;
- Marriage counseling;
- Non-medical self-help or training programs such as programs for weight control or general fitness;
- Naturopathic and homeopathic remedies and prescriptions even if prescribed by a qualified medical professional;
- Services and supplies for which the you cannot be held liable because of an agreement between the provider or facility rendering the service and another third party payer which has already paid for such service or supply;
- Services or supplies which could have been received in a hospital or program operated by a government agency or authority. This exclusion does not apply to:
  - Covered services rendered at a hospital owned or operated by the State of Oregon or any State approved community mental health and developmental disabilities program;
  - Services and supplies furnished by the Veterans Administration to you or your dependent who is a veteran of the armed forces which are not service related; or
  - Services or supplies available under Medicaid.
- Services and supplies received by a covered person while in the custody of any state or federal law enforcement authorities or while in jail or prison;
- Charges for a missed appointment;
- Services provided by the covered person's spouse, child, brother, sister, or by a parent of the covered person or spouse; and
- Services provided by any family member who lives in the covered person's home.

DENTAL COVERAGE

The City Health Plan dental care program is designed to help you and your covered dependents pay for dental expenses, both for routine care and for unforeseen treatment. The plan will cover eligible dental expenses incurred by you or a covered dependent when performed by a licensed dentist, licensed physician or a certified denturist providing services within the scope of his or her practice, and when determined to be necessary dental care by ODS Health Plans.

In order to be covered under the plan, the dental service or treatment must be appropriate and required as determined by ODS Health Plans. ODS Health Plans will determine whether or not a treatment or service is necessary dental care and may use a consulting service or peer review process to assist in making such a determination. ODS may determine that there are optional dental treatments and may consider alternative services or treatment plans when determining benefits payable under the covered dental expenses of this plan.

PREVAILING FEES

The City Health Plan dental benefits are provided through the ODS dental plan. ODS has contracted with dentists throughout the state and has approved their fee schedules for covered services. As a result, your share of the dental cost may be reduced.

Prevailing fees are those fees which satisfy and are charged by the majority of dentists in Oregon, as determined by ODS Health Plans. "Prevailing fee" in Oregon, means the fee for a single procedure which satisfied the majority (equivalent to the fifty-first (51st) percentile) of dentists in Oregon, as determined by ODS based upon a confidential fee listing accepted by ODS from participating dentists. The Prevailing fee in states other than Oregon shall be that State's Delta Affiliates non-participating dentist allowance.

The plan will pay non-participating dentists up to the prevailing fee level charged by participating dentists for the same services. For more information about the participating dentists, contact ODS at 1-800- 575-9295. For a current provider directory, contact HRRS. You can also find up-to-date dental provider listings on the ODS Health Plans website (www.odshealthplans.com) and follow the instructions for searching the ODS Dental Premier Directory.

MAXIMUM PLAN ALLOWANCE

This plan will pay providers the **Maximum Plan Allowance** for the treatment or service according to the schedule of benefits in effect on the date such treatment or service is provided to the covered person. Maximum Plan Allowance means:

- The accepted filed fee for a participating dentist; or
- The prevailing fee for a non-participating dentist.

DEDUCTIBLE

You must satisfy a $50 deductible ($25 deductible for EPEA group) each calendar year before the plan starts paying benefits. A total $150 maximum deductible per family ($75 maximum deductible per family for EPEA group), with no more than $50 (or $25 for EPEA group) from any one person in the family applying toward that maximum, must be satisfied before the plan starts paying benefits each calendar year.

CARRY-OVER DEDUCTIBLE

The deductible must be satisfied each year. However, dental expenses incurred in October, November or December which are used to meet the current year's deductible will be applied toward the deductible for the next year.

MAXIMUM DENTAL BENEFIT

The plan pays a maximum benefit for expenses you incur in each calendar year in which you are eligible for plan coverage.

See the Summary of Dental Benefits for maximum dental benefit amounts.

COVERED DENTAL EXPENSES

PREVENTIVE TREATMENT

The plan pays 100% of covered preventive treatment. This kind of treatment is payable once every six months. There is no deductible required for the following expenses:

- Routine exams;
- Routine bitewing x-rays;
- Fluoride treatment; and
- Routine cleaning.

BASIC TREATMENT

After you meet the applicable deductible, the plan pays 80% of the following covered basic treatments:

- Full mouth x-rays (one set of full mouth x-rays in a period of 36 consecutive months);
- Space maintainers for missing primary teeth;
- Temporary treatment needed to ease dental pain;

- Sealants for permanent molars (covers children ages 6 to 14, once every 3 years);
- Diagnostic x-rays and lab procedures;
- Amalgam, silicate, acrylic and composite fillings. If another restorative material is selected, such as gold foil, the plan will cover up to the cost of a silver amalgam filling. Composite, plastic, silicate, or similar restorations in posterior teeth, other than facial class V restorations on bicuspids, are considered optional services. Benefits shall be based on a corresponding amalgam restoration;
- Removal of teeth, including surgery for impacted wisdom teeth (except when due to pre-orthodontic treatment);
- Prescription drugs for dental conditions;
- Anesthesia for oral surgery;
- Root canal therapy (endodontics);
- Periodontal therapy to stop any severe and recurring symptoms, including periodontal prophylaxis and occlusal adjustments;
- Consulting with your dentist or doctor when required, except when due to pre-orthodontic treatment;
- Surgery to prepare dental ridges for prosthetic appliances;
- Oral surgery performed by your dentist or doctor within six months of an accidental injury to your jaw or natural teeth (prosthetic appliances are included);
- Emergency care and treatment of the jaw or natural teeth received within 72 hours after the first visit;
- Relining or rebasing after six months from the date of placement of a denture (one relining or rebasing in a period of 36 consecutive months);
- Inlays, onlays, and crowns when the tooth cannot be restored with a filling or when needed as a support for a bridge; and
- Repair of dentures or bridgework.

MAJOR TREATMENT

After you meet the applicable deductible, the plan pays 50% of the following covered major treatments:

- First placement of bridgework;
- First placement of partial or full dentures; and
- Bridge or denture replacement if over five years from the last placement and not serviceable, or the existing denture cannot be used because of the first placement of an opposing full denture.

Any benefits paid for temporary crowns, bridges, or dentures are subtracted from benefits paid for permanent crowns, bridges, or dentures. The total benefit paid for temporary dentures will not be more than the maximum benefit paid for permanent dentures.

ORTHODONTIC TREATMENT

50% of covered orthodontic treatment is paid by the plan. There is no deductible for the following treatment:

- Initial diagnostic procedures;
- Correction of malocclusion by wire appliances, braces and other mechanical aids; and
- Removal of teeth.

If needed, the plan includes any separate charges for the first appliances. The plan pays according to the type of dental treatment incurred on the day treatment begins.

PRE-TREATMENT ESTIMATE

Prior to any orthodontic work, your dentist must send in a pre-treatment estimate form to ODS. ODS will review the service or treatment before it begins. The pre-treatment estimate is designed to inform you of the amount of the benefits paid under the plan before you incur major expenses.

DENTAL EXPENSES NOT COVERED

The following services and supplies are not covered under the plan:

- Charges from providers that exceed "prevailing fees," as determined by ODS;
- Services, procedures, supplies and drugs constituting experimental or investigational treatment as determined by ODS;
- Services which are paid for by the government (except services provided by a Veteran's Hospital for non-service related illnesses or injuries);
- Services for which you or your covered dependent are not charged, or for which the charges are waived;
- Treatment of an illness or injury for which you are covered under Workers' Compensation or similar State or Federal programs, except services provided by a Veterans Hospital for non-service related illnesses or injuries (this exclusion does not apply to medical assistance provided under Medicaid);
- Dental checkups or dental screening by your employer, a school or a government;
- Dietary planning, plaque control or oral hygiene instructions;
- Missed appointments or completion of claim forms;
- Any restorations or treatment used mainly to keep periodontally involved teeth from moving or to restore occlusion;
- Replacement of a lost or stolen prosthetic device or any other device or appliance;
- Any dentures, crowns, inlays, onlays, bridgework or other appliances or services mainly for increasing vertical dimension;
- Illness or accidental injury resulting from war an act of war, or which occurs while you are in active military service for any country and covered under the plan.

- Tooth or denture implants;
- Precision attachments;
- Dental treatment for cosmetic reasons except for cosmetic dental surgery which is required:
    - Due to an injury;
    - For crown facings on molar teeth if needed as a result of accidental injury; or
    - For a birth defect or illness of a covered dependent child born to a covered person.
- Replacement of dentures or bridgework if less than five years from the last denture or bridgework placement, except for denture or bridgework placement if the existing dentures or bridgework cannot be used because of first placement of an opposing denture.
- The first placement of dentures or bridgework to replace teeth removed before you or your covered dependent were eligible for coverage under the plan, unless:
    - The expenses were eligible under the City's prior group dental plan; and
    - The teeth were removed while you or your covered dependent were covered under the City's prior group dental plan.

VISION COVERAGE

The plan covers vision care if the examination is provided by an ophthalmologist or an optometrist.

COVERED VISION EXPENSES

You do not have to pay a deductible for vision coverage. The plan covers:

- Complete eye exams every 12 consecutive months; and
- Prescription lenses and frames every 24 consecutive months if the prescription changes; **OR**
- Prescription contact lenses every 24 consecutive months if the prescription changes.

See the Summary of Vision Benefits for the schedule of benefits.

VISION EXPENSES NOT COVERED

Services and supplies not listed in the Summary of Vision Benefits are not covered, such as:

- Sunglasses, safety glasses or goggles;
- Replacement of lenses, including lenticular lenses or frames, unless an eye exam shows a vision change that requires a new prescription lens;
- Replacement of lost, stolen or broken lenses or frames;
- Benefits payable under Workers' Compensation Act or similar law;
- Surgery or medical treatment of the eyes;
- Services and supplies not listed in the Summary of Vision Benefits;
- More than one complete eye exam per 12-consecutive month period;
- More than one pair of frames and/or lenses per 24-consecutive month period; and
- Any expenses related to a radial keratotomy, eximer laser refractive surgery or similar procedures.

COORDINATION OF BENEFITS

HOW COORDINATION OF BENEFITS WORKS

Many employees are covered by more than one health care plan. For example, if a husband and wife both work, they may be protected under a medical, dental, and/or vision plan maintained by each of their employers. If each spouse covers the other and their children, there are standard procedures governing how benefits are paid.

"Coordination of Benefits" is a method for determining the amount that each plan should pay when a person is covered under two or more plans. It determines which plan is primary and which plan is secondary. The primary plan (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of the Coordination of Benefits provision. The secondary plan (the plan that pays benefits after the primary plan) will limit the benefits it pays so that the sum of its benefits and all other benefits paid by the primary plan will not exceed the greater of

- 100% of total covered expense; or
- The amount of benefits it would have paid had it been the primary plan.

For purposes of the Coordination of Benefits rules, a "plan" means any of the following coverages, including coverages which provide benefit payments or services to an insured person for hospital, medical, surgical or dental care:

- Group, blanket or franchise insurance (except student accident insurance);
- Prepayment coverage on a group basis, including HMO (Health Maintenance Organization) coverage;
- Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Coverage under government programs, other than Medicaid, and any other coverage required or provided by law;
- Group or individual automobile "no fault" coverage; or
- Other arrangements of insured or self-insured group coverage.

If one of the plans has no provisions for Coordination of Benefits, it is always the primary plan, and therefore, pays first. If both plans have Coordination of Benefit provisions, the following rules apply:

- The plan that covers the person as an employee or member is primary and the plan that covers the person as a dependent is secondary.
- Benefits of the plan which covers a dependent child whose parents are not separated or divorced, will be covered first by the plan of the parent whose birthday falls earliest in the year. If the birthday falls on the same day, then the plan that has covered the parent the longest becomes primary and pays benefits first.

- If a dependent child's parents are separated or divorced, benefits for the dependent child are determined in the following order:
    - First, the plan of the parent with custody of the child;
    - Then, the plan of the spouse of the parent with the custody of the child; and
    - Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- The plan that covers a person as an active employee (or a dependent of an active employee) pays first, with a plan covering a person as a retired or laid-off employee (or a dependent of that retired or laid-off employee) paying second.
- If none of the above rules apply, the plan that has covered the person for a longer period pays first.

MEDICARE COORDINATION OF BENEFITS

In certain situations, the City Health Plan provides primary coverage when both Medicare and the plan cover you or a dependent. This means that the plan pays benefits first and Medicare pays benefits second. Those situations are:

- When you or your enrolled spouse is age 65 or over and by law Medicare is secondary to the plan;
- When you or your enrolled dependents incur covered services for kidney transplant or dialysis and by law Medicare is secondary to the plan for the first 30 months of coverage; and
- When you or your enrolled dependents are entitled to benefits under Section 226(b) of the Social Security Act (Medicare Disability) and by law Medicare is secondary to the plan.

To the extent permitted by law, this plan will not pay benefits for any part of covered expenses to the extent the covered expense is actually paid or would have been paid under Medicare Part A or B, had the covered person properly enrolled in Medicare and applied for benefits. This means that for coordination of benefits purposes, this plan will estimate what Medicare would have paid and reduce benefits based on the estimate. This plan will not pay benefits toward any part of a covered expense to the extent the covered expense is covered by Medicare.

In addition, if this plan is secondary to Medicare, the plan will not pay for any part of expenses incurred from providers who have opted out of Medicare participation.

THIRD PARTY LIABILITY

Third-party liability refers to claims that are the responsibility of someone other than you or the plan. In all third-party liability situations, this plan's coverage is secondary. If benefits are to be paid under the plan for an illness or injury which you think may be the responsibility of another party, such as a motor vehicle accident or workplace injury, be sure to contact ODS as soon as possible. When ODS receives a claim that it thinks may be the responsibility of a third party, it will send you a questionnaire asking for more specific information to help it determine responsibility.

If you receive a settlement for an illness or injury and the plan has paid your medical claims for that illness or injury, you must pay the plan back for the cost of your treatment. If ODS suspects that a third party may be responsible for your illness or injury, it will ask you to sign an agreement specifying those terms before the plan will pay your medical claims.

Before you accept any settlement in a third-party liability case, you must let ODS know the terms of the settlement and notify the third party that the plan has an interest in the settlement. If you have ongoing medical bills after you receive the settlement, this plan will not pay those bills until you have exhausted your settlement.

The plan and the City of Eugene also have the right to recover money from a third party who may be responsible for paying the costs of your treatment. We may also assert your rights and sue in your name, if necessary.

The contractual rules for third-party liability are complicated and specific. If you have a question or concern about a third-party claim, please call ODS at 1-877-605-3229.

CONTINUING YOUR COVERAGE

COBRA CONTINUATION COVERAGE

As a member of the City Health Plan, you and/or your eligible dependents may continue your health care coverage (medical, dental, and vision) on a self-pay basis under certain qualifying events. This continuation coverage is made available pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

COBRA continuation coverage is also available to persons who are covered under the plan by reason of their status as a domestic partner of a covered employee or as a dependent of a domestic partner.

You, your domestic partner, and your dependents, as applicable, may only continue the health coverage that was in effect when the qualifying event took place. Thus, if you had the combined health (medical/dental/vision) coverage, you may continue that combined coverage. You may also elect to only continue the medical (and not dental/vision) coverage. You may also thereafter change your coverage during the open enrollment period. The coverage will be the same as that provided under the City of Eugene's benefit plans for active employees.

A child who is born to or adopted by you while you are receiving continuation coverage is also entitled to continuation coverage. Written notice of a child born to or adopted by you while you are receiving continuation coverage must also be provided to HRRS within 60 days of that event.

Individuals entitled to COBRA continuation coverage have the same rights afforded similarly-situated plan participants who are not enrolled in COBRA. COBRA participants may add newborns, new spouses, and adopted children (or children placed for adoption) as covered dependents in accordance with the plan's eligibility and enrollment rules, including the plan's special enrollment rules.

QUALIFYING EVENTS

If you are a City employee, you will become a qualified beneficiary if you will lose your coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse (or domestic partner) of a City employee, you will become a qualified beneficiary if you will lose your coverage under the plan because any of the following qualifying events happens:

- Your spouse (or domestic partner) dies;

- Your spouse's (or domestic partner's) hours of employment are reduced;
- Your spouse's (or domestic partner's) employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse (or termination of your domestic partnership).

Your dependent children covered under the plan, will become qualified beneficiaries if they will lose coverage under the plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- Parents become divorce or legally separated (or termination of domestic partnership); or
- The child stops being eligible for coverage under the plan as a "dependent child."

NOTIFICATION OF QUALIFYING EVENT--YOUR RESPONSIBILITY

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

The Plan Administrator is the City of Eugene Benefits Program, Human Resource and Risk Services, 777 Pearl Street, Room 101, Eugene, OR 97401; telephone (541) 682-8868.

The COBRA Administrator is BestChoice Administrators (BCA), PO Box 67240, Portland, OR 97268-1230; telephone 1-800-822-3173.

You Must Give Notice of Some Qualifying Events

For the qualifying events of divorce or legal separation of the employee and spouse, termination of domestic partnership, or a dependent child's losing eligibility for coverage as a dependent child, **you must notify the Plan Administrator within 60 days after the qualifying event occurs**. You must send this notice to: City of Eugene Benefits Program, Human Resource & Risk Services, 777 Pearl Street, Room 101, Eugene OR 97401. Or you may contact Benefits Program staff by telephone at (541) 682-8868. Your notice must include the nature and date of the qualifying event, the name of the person losing coverage, and a mailing address for that person.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses or domestic partners, and parents may elect COBRA continuation coverage on behalf of their children. For

each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that the plan coverage would otherwise have been lost.

LENGTH OF CONTINUATION COVERAGE

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, termination of domestic partnership, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration (SSA) to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

In order to be eligible for this extended continuation coverage period, the disabled individual (or someone on the individual's behalf) must notify the COBRA administrator of the SSA disability determination within 60 days of the issuance of the determination by the SSA (or, if later, within 60 days of the end of the month in which the employee terminates employment or transfers to part-time status and before the end of the otherwise applicable 18-month continuation period, whichever period ends first.) The notice must include a copy of the SSA determination. If the notice of the SSA determination is not provided to the COBRA Administrator within this time period, then the 11 month extension of coverage will not be available. .

If the SSA later makes a final determination that the individual is no longer disabled, the individual must notify the COBRA Administrator within 30 days of the final determination by the SSA.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse or domestic partner and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to the spouse (or domestic partner) and any dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse, domestic partner or dependent child to lose coverage under the plan had the first qualifying event not occurred.

In all cases, you must make sure that the COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: BestChoice Administrators (BCA), PO Box 67230, Portland, OR 97268-1230; telephone 1-800-822-3173.

Your notice must include the nature and date of the second qualifying event, the name of the person losing coverage, and a mailing address for that person.

Once Notification is Given

When the COBRA Administrator is notified that one of the above events has occurred, it will notify you or your covered dependents of the right to elect continuation coverage. Under this provision, that person has 60 days from the date coverage would otherwise be lost because of one of the events described above or 60 days from the date of notification from the COBRA administrator, whichever is later, to elect continuation coverage. Failure to elect continuation coverage within that period will cause coverage under the plan to end as it normally would under the terms of the plan.

COST OF CONTINUATION COVERAGE

You or your covered dependent is responsible for the full cost of continuation coverage and any administrative fee assessed. Payment for continuation coverage for any month is due on the first day of the month, and, in all events, must be made within 30 days of the due date. The only exception is the premium payment for continuation coverage during the period preceding the election, which must be made within 45 days of the date of election. Premium rates may change annually.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA continuation coverage will end for a person (i.e., you, your spouse, domestic partner, or dependent, as applicable) if one of the following events occurs:

- Failure to timely pay the full required continuation premium;
- The City of Eugene no longer offers group health coverage;

- The person later becomes covered under any other medical, dental, or vision plan. However, coverage under another plan will not cause continuation to end if the other plan excludes or limits coverage for a pre-existing condition of the person;
- The person later becomes entitled to Medicare benefits under Part A, Part B, or both;
- In the case of a person who qualified for an extra 11 months continuation coverage based on the disability and persons receiving continuation coverage by reference to such disabled person, the date of a final determination by the Social Security Administration that the person is no longer disabled;
- The applicable period of continuation ends; or
- Coverage is terminated for cause (e.g., a covered person submits a fraudulent claim).

Continuation coverage may also be terminated for any reason the plan would terminate coverage of an employee or dependent not receiving continuation coverage. Once COBRA Continuation coverage ends, it cannot be reinstated.

TERMINATION FOR GROSS MISCONDUCT

Pursuant to federal law, employees who are terminated from employment for gross misconduct are not entitled to COBRA continuation coverage under the plan. The spouse (or domestic partner) and dependents of an employee terminated for gross misconduct are also not entitled to COBRA continuation coverage.

The City will look at the specific circumstances surrounding each disciplinary termination in order to determine whether an employee's termination was for gross misconduct. For purposes of the plan, "gross misconduct" means conduct that reflects a willful disregard of the City's interests or of the employee's duties and obligations to the City. Examples of gross misconduct include, but are not limited to, willful violations or disregard of City policy; theft, fraud, official misconduct, and other acts that constitute a violation of the law; and dishonesty.

ADDRESS CHANGES

In order to protect your family's rights, you should keep HRRS informed of any changes in the addresses of family members. You should keep a copy, for your records, of any notices you sent to HRRS or to the COBRA Administrator.

QUESTIONS

If you have questions about your COBRA continuation coverage, you can contact Human Resource and Risk Services or BestChoice Administrators (BCA), PO Box 67230, Portland Oregon 97268-1230; telephone 1-800-822-3173.

CONTINUATION FOR SPOUSES OVER AGE 55

If you die, become divorced or legally separated, or discontinue your domestic partnership, and your covered spouse or domestic partner is then age 55 or over, your spouse or domestic partner and any covered dependents may continue medical coverage under the City Health Plan on a self-pay basis until the earliest to occur of the following:

- Failure to pay premiums when due;
- Termination of the plan, unless another group health plan is made available by the City of Eugene to its employees; or
- Your legally separated, divorced or surviving spouse or domestic partner becomes covered under another group health plan or becomes eligible for Medicare.

In order to be eligible for continued coverage, your spouse, domestic partner or dependent must give written notice of the legal separation, termination of marriage or domestic partnership, or death of the employee to HRRS within:

- Thirty days of the date of the employee's death;
- Sixty days of the date of legal separation (or dissolution of domestic partnership); or
- Sixty days of the date of entry of the divorce decree.

RETIREMENT CONTINUATION

If you retire under the Oregon Public Employees Retirement System (PERS) or Oregon Public Service Retirement Program (OPSRP) immediately upon your termination of employment from the City of Eugene, you can continue your health insurance coverage through the City's plan on a self-pay basis , as provided under state law. Retirees have the choice of COBRA or the Retiree Continuation Coverage, but not both. This coverage is explained more fully in the Retired Employee Coverage section of this handbook.

EXTENSION OF HOSPITAL COVERAGE

A covered person who is hospitalized at the time of the termination of coverage under the plan will continue to receive benefits for services received while hospitalized until discharged from the hospital or until the limits of coverage under the plan have been reached, whichever is earlier. Continuation of coverage under this provision will be concurrent with COBRA continuation for the period that the employee is also eligible for COBRA continuation.

CONTINUATION DURING STRIKE OR LOCKOUT

In the event of cessation of work by employees due to a strike or lockout, coverage under the plan will continue in effect with respect to those employees who:

- Were covered by the plan on the date of the cessation of work;
- Continue to pay their individual contribution; and
- Assume and timely pay the contribution due from the City.

Continuation of coverage under this provision will be concurrent with COBRA continuation for the period that the employee is also eligible for COBRA continuation.

CONTINUATION FOR HEALTH CARE FLEXIBLE SPENDING ACCOUNT

If you elect to participate in a Health Care Flexible Spending Account (FSA), then upon your termination of employment, you may continue your participation in the Health Care FSA, as discussed in the Flexible Spending Account section of this handbook.

MILITARY LEAVE

To the extent required under the Uniformed Services Employment and Reemployment Rights Act, if an employee was covered under this plan immediately prior to entering duty with any of the armed forces of the United States of America, then coverage may be continued under the plan for up to 24 months or the period of uniformed service leave, whichever is less. The coverage is conditioned upon the employee timely paying any required contributions toward the cost of the coverage during the leave. If the leave period is less than 30 days, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102 percent of the cost of coverage.

OREGON MEDICAL INSURANCE POOL COVERAGE

A covered person whose coverage under the plan has terminated may be eligible to secure major medical insurance coverage on a self-pay basis through the Oregon Medical Insurance Pool (OMIP). OMIP does not form part of the plan, nor is it sponsored or endorsed in any way by the City of Eugene. Rather, OMIP is provided through the Oregon Department of Consumer & Business Services, and is currently administered by Regence Blue Cross and Blue Shield of Oregon.

In order to secure coverage under the OMIP, the following conditions must be satisfied:

- The covered person must have been continuously covered under the City Health Plan for at least 180 days;

- The covered person must apply for coverage under the OMIP within 63 days after the date of eligibility for such coverage;
- The covered person must be an Oregon resident at the time of the application for coverage; and
- As of the date of first becoming eligible for coverage under the OMIP, the covered person is neither:
    - Covered under another group health plan (such as that of a spouse); nor
    - Eligible for Medicare.

Upon proper application and the payment of the applicable premiums, coverage under the OMIP will generally become effective as of the day following the covered person's termination of coverage under the plan. However, if the covered person is eligible for COBRA continuation coverage under the City Health Plan, then coverage under OMIP will not become effective prior to the full COBRA continuation coverage period available to the covered person. Thus, a covered person who declines COBRA continuation coverage, or allows such continuation coverage to terminate by not timely paying the required premiums, will not be eligible for OMIP coverage for the period that the COBRA continuation coverage under the plan was available.

For further information regarding the OMIP, and to receive an application for coverage, you may call **Regence Blue Cross and Blue Shield member services at 1-800-848-7280**.

If you have problems obtaining OMIP coverage, you may contact the Health Programs Unit of the Oregon Insurance Division at 1-503-947-7985.

RETIRED EMPLOYEE COVERAGE

ELIGIBILITY

Oregon law requires public employers to allow retired employees the option of continuing to purchase health insurance coverage from the employer after retirement. An employee of one of the following groups who retires under the Oregon Public Employees Retirement System (PERS) or Oregon Public Service Retirement Program (OPSRP) (or any other retirement system or plan to which contributions were paid by the City on the employee's behalf) immediately upon their termination of employment from City of Eugene service (or is no longer actively employed due to disability), may elect to continue to be covered under the plan on a self-pay basis:

- American Federation of State, County, and Municipal Employees (AFSCME);
- Eugene Police Employees' Association (EPEA);
- Non-Represented;
- International Association of Firefighters (IAFF); or
- International Alliance of Theatrical Stage Employees (IATSE) regular employees as specified by the most recent labor agreement between IATSE and the City.

COVERAGE OPTIONS

A retired employee may elect either:

- Medical-only coverage; or
- Medical, dental and vision coverage.

If the retired employee initially elects medical-only coverage, then dental and vision coverage can later be elected, but not until a subsequent open enrollment period.

DURATION OF COVERAGE

- A retired employee who has elected to remain covered under the plan, and the retired employee's spouse or domestic partner, may continue that coverage under this plan on a self-pay basis until that person is eligible for Medicare benefits.

- The divorce of the retired employee and the spouse, or a discontinuance of the domestic partner relationship, after the spouse or domestic partner attains age 55, does not affect the spouse's or domestic partner's right to continued coverage under the plan.

- If such divorce or domestic partnership discontinuance occurs before the spouse or domestic partner attains age 55, the spouse or domestic partner will then cease to be eligible for retired employee coverage, but may then be eligible for COBRA continuation coverage. The maximum period of such COBRA continuation coverage, if available, will be determined by reference to the retired employee's retirement date. Accordingly, the COBRA continuation coverage period for such a spouse will run concurrently with the spouse's retired employee coverage.

- Eligible dependent children of the retired employee may continue coverage on a self-pay basis until they attain the age of 18. A dependent child who so ceases to be eligible for retired employee coverage may then be eligible for COBRA continuation coverage. The maximum period of such COBRA continuation coverage, if available, will be determined by reference to the retired employee's retirement date. Accordingly, the COBRA continuation coverage period for such a dependent child will run concurrently with the child's retired employee coverage.

ELECTION DEADLINE

Retired employee coverage under the plan is conditioned upon the retired employee timely electing such coverage and timely paying the required self-pay premiums. The employee must retire under PERS or OPSRP immediately upon termination from the City of Eugene and must elect to secure retired employee coverage no later than 60 days after the employee's retirement date.

MONTHLY PAYMENTS

A retired employee is responsible for the full cost of retired employee continuation coverage and any applicable administrative fee assessed. Payment for coverage for any month is due on the first day of the month, and, in all events, must be made within 30 days of the due date. The only exception is the premium payment for retired employee coverage during the period preceding the election of such coverage, which must be made within 45 days of the date of election. In all regards, retired employee coverage will terminate as of the last day of the prior month for which the monthly self-pay premium was not timely made.

NO REINSTATEMENT OF COVERAGE

A retired employee who fails to timely elect retired employee coverage, or who once electing such coverage has such coverage terminated as a result of failing to timely pay the required premium or for any other reason, will forever thereafter cease to be eligible for retired employee coverage. Once the retired employee coverage is terminated, it will not be reinstated.

SUBMITTING A MEDICAL, DENTAL OR VISION CLAIM

HOW TO RECEIVE BENEFITS

To receive benefits, you or your dependent (or someone on your behalf) must submit a claim to ODS Health Plan, Inc. Submitting a claim involves the following process:

- For each claim you must submit the claim form and itemized bill which must include the following:
  - Person or firm making the charge;
  - Your name, Social Security Number and date of birth;
  - Name and age of patient;
  - Dates of treatment;
  - Services rendered and amount of charge; and
  - Nature of illness/injury in narrative or ICDA code for which charge was made. ("Balance Forward" bills will not be accepted.)

- Submit claims within 90 days after the date of the treatment, or as soon as reasonably possible.

- **Dental** claims should be sent to:

  ODS Health Plan
  601 S.W. Second Avenue
  Portland OR 97204
  1-877-277-7280

- **Vision** claims should be sent to:

  ODS Health Plan
  PO Box 40384
  Portland OR 97240-0384
  1-877-605-3229

ODS will process the claim form and make payment or issue a denial notice in its capacity as claims administrator.

A claim will not be accepted later than one year and 90 days following the date the expense was incurred, except in a case of legal incapacity.

CLAIMS APPEAL

ODS Health Plan, Inc. has established a formal process by which you may appeal the denial of a claim made under the plan. Before taking action under the formal appeals process, you should call or write the ODS Customer Service Department (at **1-877-605-3229**). ODS will try to resolve the problem informally.

- **Appeal of Claim Denial.** If you disagree with decisions made regarding coverage or services provided under the plan (including, for example, a denial of a request for services, a denial of benefits or a disagreement regarding the amount of benefits), you may appeal the decision and ask for a resolution. The appeal must be made within 60 days of the date of ODS's action on the claim. You may also call the ODS Customer Service Department to discuss the issue. In that case, it may be possible to resolve the question at that time without having to file a formal appeal.

- **First Level Appeal.** If you wish to formally appeal a claim decision, you may request a First Level Appeal. Under this step, you should submit the appeal to ODS in writing, along with any additional information having a bearing on the matter. ODS will acknowledge in writing its receipt of the appeal within seven (7) days thereof and will thereupon commence a review of the matter. The appeal will receive a full review by persons who were not involved in the initial determination.

A decision regarding the appeal will be made by ODS. Written notice of the appeal decision will be provided to you within thirty (30) days after the receipt of the appeal. The written notice of the disposition of the appeal will include the basis for the decision, along with information regarding your right to a Second Level Appeal.

- **Second Level Appeal.** If after the First Level Appeal you are still dissatisfied with a claim denial decision, a request may be made for a Second Level Appeal. The Second Level Appeal will be reviewed by a committee comprised of persons who were not previously involved in the claim denial or the First Level Appeal.

ODS will acknowledge in writing its receipt of the Second Level Appeal within seven (7) days thereof, and will thereupon commence a review of the matter. A decision regarding the appeal will be made by ODS within twenty-five (25) days after its receipt of the appeal request. Written notice of the appeal decision will be provided to you within five (5) days after the decision has been made.

- **Right to Appear.** You have the right to appear before the review committee in connection with either a First Level Appeal or a Second Level Appeal (or both). If you cannot appear, you may request that arrangements be made so that you may communicate with the review committee by conference call or other appropriate technology. ODS will allow requests for practitioners or a representative to act on your behalf in connection with the appeal process.

- **External Review**. If a covered person is not satisfied with the outcome of the Second Level Appeal, and the claim involves a matter prescribed below, the covered person may request that the claim be reviewed by an independent review organization appointed by the Oregon Insurance Division. The dispute must relate to an adverse decision in regard to one or more of the following:

    - Whether a course or plan of treatment is medically necessary;
    - Whether a course or plan of treatment is experimental or investigational; or

- Whether a course or plan of treatment that a covered person is undergoing is an active course of treatment for purposes of continuity of PPO care rates under this plan.

The claims administrator agrees to be bound by the decision of the independent review organization, but only with respect to a matter described above. The availability of the external review process is further subject to the following conditions:

- The covered person must have exhausted the First and Second Levels of Appeal described in this section, unless the claims administrator waives the requirement;
- The covered person must apply in writing for external review not later than the 180th day after receipt of the final written decision following the Second Level Appeal (unless such Second Level Appeal has been waived by the claims administrator);
- The covered person must sign a waiver granting the independent review organization access to the individual's medical records; and
- The covered person must provide complete and accurate information to the independent review organization in a timely manner.

GRIEVANCE PROCESS

ODS has established procedures for you to voice any dissatisfaction with the service provided under the plan, or any other problem not directly covered by the plan's claim appeals process described above. These procedures cover grievances, complaints and inquiries, as described below.

- **"Grievance"** means a written complaint submitted by or on your behalf regarding either of the following:

  - The availability, delivery or qualify health care services, including a complaint regarding an adverse determination made pursuant to a utilization review; or
  - Claim payment, handling or reimbursement for health care services.

- **"Complaint"** means an expression of dissatisfaction about a specific problem encountered by you or about a decision by an agent acting on behalf of ODS. A complaint includes a request for action to resolve the problem or change the decision. An inquiry does not include a complaint.

- **"Inquiry"** means a written request for information or clarification regarding:

  - A specific problem encountered by you;
  - A decision by ODS or an agent acting on behalf of ODS; or
  - Any subject matter related to the plan.

If you have a complaint regarding the quality of medical care, the timeliness of care, the access to care or the appropriateness of care, you may register the complaint with ODS and ask for a review of the clinical judgments involved. You may do this either by calling the ODS Customer

Service Department, or by submitting the complaint in writing to ODS. The complaint will be documented and a review of the matter will be conducted. If you are unable to complete a written complaint, you should contact the ODS Customer Service Department and ask for assistance.

A written acknowledgment of the receipt of the complaint will be provided within seven days of its receipt. The decision regarding the complaint will generally be made within 30 days of its receipt. However, ODS may have an additional 15 days to resolve the issue if, before the end of the 30-day period, it gives notice of the delay, explaining the specific reason for the delay, to you (or to your representative).

WAIVER OF DEADLINES

The timelines pertaining to the disposition of appeals and grievances addressed in this Section do not apply:

- When the time period is too long to accommodate the clinical urgency of the situation;
- You do not reasonably cooperate in the appeal or grievance process; or
- Circumstances beyond either the control of you or ODS prevents that party from meeting the deadlines, but only if the party which is unable to comply with the deadline gives a notice explaining the circumstances to the other party.

ADDITIONAL RIGHTS

You have the right to file a complaint or seek other assistance from the Oregon Insurance Division. Assistance is available:

By calling: (503) 947-7984
By writing: Oregon Insurance Division
Consumer Protection Unit
350 Winter Street, NE, Room 440-2
Salem, Oregon 97310
Or through the Internet at http:/ /www.cbs.state.or.us/external/ins/

THE PLAN IS NOT RESPONSIBLE FOR THE QUALITY OF MEDICAL, DENTAL, OR VISION CARE

In all cases, covered persons have the exclusive right to choose their hospital or provider of care. This plan is not responsible for the quality of medical, dental or vision care a person receives, since all those who provide care do so as independent contractors. This plan cannot be held liable for any claim or damages connected with injuries suffered by a covered person while receiving medical, dental or vision services or supplies.

PATIENT PROTECTION ACT

The Patient Protection Act, also known as Senate Bill 21, was passed by the 1997 Oregon State Legislature to assure that patients, physicians and providers are informed about the benefits and policies of their health insurance plans. This question and answer section was provided by ODS to outline many of the terms and conditions of the City Health Plan, as administered by ODS

1. What are a member's rights and responsibilities?

Members have the right to:

- Be treated with respect and dignity at all times.
- Have access to urgent and emergency services, 24 hours a day, 7 days a week.
- Know what their rights and responsibilities are. Members will be given information about their health plan and how to use it. Members will be given information about the physicians and providers who will care for them. This information will be provided in a way that members can understand.
- Be informed about their health.
- Refuse care. Members have the right to be advised of the medical result of their refusal.
- Receive services as described in the Summary Plan Document.
- Have their medical and personal information remain private. Information will not be given out unless allowed by the member or required by law.
- Make a complaint or appeal about any aspect of their care or service. Members have a right to a quick response to their complaint or appeal. Members are welcome to make suggestions to the plan.
- Have a statement of wishes for treatment on file. A statement of wishes for treatment is known as an Advanced Directive.
- Have a power of attorney filed. A power of attorney allows the member to give someone else the right to make health care choices when the member is unable to make these decisions.

Members have the responsibility to:

- Read the Summary Plan Document to make sure they understand the plan. Members are advised to call ODS with any questions.
- Treat all physicians and providers and their staff with courtesy and respect.
- Give all the facts needed for their physician or provider and the plan to provide good health care.
- Help make decisions about their medical care and form a treatment plan.
- Follow instructions for care they have agreed to with their physician or provider.
- Take their medical identification card with them when medical care is needed. Let physicians and providers know they are covered by ODS.
- Tell physicians and providers if there is any other insurance.
- Reimburse ODS Health Plan, Inc. from any third party payments. An example of this may be an auto accident claim.

- Keep appointments and be on time. If this is not possible, members must call ahead of time to let the physician or provider know they will be late or cannot keep their appointment.
- Seek preventive services. This should be done on a regular basis.

If you have any questions about these rights and responsibilities, please call the ODS Medical Customer Service Department at (503) 243-3962 or toll-free at (877) 605-3229. The TDD/TTY number (for hearing and speech impaired) is (800) 433-6313.

2. What do I do if I have a medical emergency?

If you believe you have a medical emergency you should call 9-1-1 or seek care from the nearest appropriate physician or provider, such as a physician's office or clinic, urgent care facility or emergency room.

3. How will I know if benefits are changed or terminated?

It is the responsibility of your employer to notify you of benefit changes or termination of coverage. If your group contract terminates and your employer does not replace the coverage with another group contract, your employer is required by law to inform you in writing of the termination.

4. If I am not satisfied with my health plan, how do I voice a grievance or file an appeal?

You can voice a grievance or file an appeal by contacting the ODS Medical Customer Service Department at (503) 243-3962, toll-free at (877) 605-3229 or (800) 433-6313 (for hearing impaired), or by writing a letter to ODS Health Plan, Inc. (P.O. Box 40384, Portland, Oregon 97240). See the booklet section titled Grievance and Appeals for complete information.

You may also contact the Oregon Insurance Division as follows:

By calling: (503) 947-7984
By writing: Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, Oregon 97310

Or through the Internet at http://www.cbs.state.or.us/external/ins/

5. What are your prior authorization and utilization review criteria?

Prior authorization, also known as preauthorization, is the process we use to determine the medical necessity of a service before it is rendered. Contact the ODS Medical Customer Service Department at 877-605-3229 for a list of services that should be preauthorized. Many types of treatment may be available for certain conditions; the preauthorization process helps your physician work together with you, other providers, and ODS to determine the treatment that best meets your medical needs and to avoid duplication of services.

An approved preauthorization is your assurance that your medical services won't be denied because they don't meet the contract definition of "medical necessity."

Utilization review is a process in which ODS examines services a member receives to ensure that they are medically necessary – appropriate with regard to widely accepted standards of good medical practice. For further explanation, look at the definition of "medically necessary" in your benefits booklet.

Except in the case of fraud or misrepresentation, prior authorization for benefit coverage and medical necessity shall be binding if obtained no more than 30 days prior to the date the service is provided, and prior authorization for enrollee eligibility shall be binding if obtained no more than five business days prior to the date the services is provided.

If you would like a written summary of information that ODS may consider in their utilization review of a particular condition or disease simply call 877-605-3229.

6. How are important documents, such as my medical records, kept confidential?

ODS has a written policy to protect the confidentiality of health information. Only employees who need to know in order to do their jobs may access enrollee personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing your coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Oregon law requires insurers to obtain a written authorization from the enrollee or his or her representative before disclosing personal information. One exception to the need for a written authorization is disclosure to a designee acting on behalf of the insurer for the purpose of utilization management, quality assurance, or peer review.

7. How can I participate in the development of ODS's corporate policies and practices?

Your feedback is very important to us. If you have suggestions for improvements about your plan or our services, we would like to hear from you.

We have formed some advisory committees – which include the Group Advisory Committee for employers, and the Quality Council for health care professionals – to allow participation in the development of corporate policies and to provide feedback. The committees generally meet two times per year.

Physical Address:
ODS Health Plan, Inc.
601 SW Second Avenue
Portland, Oregon 97204

Internet Address:
www.odscompanies.com

Please note the size of the committees may not allow us to include all those who indicate an interest in and are eligible to participate.

8. My neighbor has a question about the policy he has with ODS, but he doesn't speak English very well. Can you help?

Yes. Simply have your neighbor call 877-605-3229. An ODS representatives will coordinate the services of an interpreter over the phone.

9. What additional information can I get from ODS Health Plan, Inc. upon request?

The following documents are available by calling a medical customer service representative:

- A copy of ODS's annual report on complaints and appeals.
- A description of ODS's efforts to monitor and improve the quality of health services.
- Information about procedures for credentialing network physicians and providers and how to obtain the names, qualifications, and titles of the physicians or providers responsible for an enrollee's care.
- Information about ODS's prior authorization and utilization review procedures.

10. What information can I get about ODS Health Plan, Inc. from the Oregon Insurance Division?

The following information is available from the Oregon Insurance Division:

- The results of all publicly available accreditation surveys.
- A summary of health promotion and disease prevention activities.
- An annual summary of grievances and appeals.
- An annual summary of utilization review policies.
- An annual summary of quality assessment activities.
- An annual summary of scope of network and accessibility of services.

To obtain any of this information, write to:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, Oregon 97310

Or call (503) 947-7984, or visit the web site at http://www.cbs.state.or.us/external/ins/ or send an e-mail to: dcbs.insmail@state.or.us

HIPAA PRIVACY RULES

OVERVIEW

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations include provisions designed to protect the privacy of health information concerning individuals covered under a group health plan. However, these laws recognize that the City and certain of its employees may have the need for access to, and the use of, such health information in order to perform administration functions with respect to the plan. The laws thus permit the use and disclosure of such health information by the City and its designated employees, subject to prescribed restrictions that are required to be expressly identified and acknowledged in the governing plan document. Toward that end, the City's use or disclosure of protected health information of persons covered under the plan shall be subject to the terms and conditions prescribed in this Section.

DEFINITIONS

When used in this Section, certain terms have the respective meanings set forth below.

- **"Covered Individual"** means a person who is covered under the plan and who is the subject of the PHI at issue.
- **"Disclose"** means, in regard to any PHI, to release, transfer, provide access to, or divulge in any other manner of individually identifiable health information to any entity or to any person who is not an employee or other member of the City's workforce.
- **"HHS"** means the U.S. Department of Health and Human Services.
- **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996.
- **"HIPAA Privacy Rules"** means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
- **"Plan Administration Functions"** means any of the following functions or activities that the City performs on behalf of the plan:
    - Quality assessment and improvement activities, population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, or related functions that do not include treatment;
    - Monitoring and evaluating the performance of any plan service provider, or of the plan itself;
    - Activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
    - Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
    - Business planning and development, such as conducting cost management and planning related analyses related to managing and operating the plan, prescription

drug formulary development and administration, or the development or improvement of methods of payment or plan coverage;
    - Business management and general administrative activities of the plan, including, but not limited to, activities relating to the implementation of and compliance with the HIPAA privacy rules, the resolution of claims and internal grievances arising under or with respect to the plan, and creating a summary of or "de identifying" PHI;
    - Activities undertaken by the City on behalf of the plan to obtain premiums or contributions, to determine or fulfill the plan's responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care;
    - Determinations of eligibility or coverage (including the coordination of benefits or the determination of cost sharing amounts), and the adjudication or subrogation of health benefit claims;
    - Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop loss insurance and excess of loss insurance), and related health care data processing;
    - Review of health care services with respect to medical necessity, coverage under the plan, appropriateness of care, or justification of charges;
    - Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
    - Disclosures to a consumer reporting agency of any of the following components of PHI relating to collection of premiums or reimbursement of benefit payments: name and address, date of birth, social security number, payment history, account number, and name and address of the plan.
- **"Privacy Official"** means the person appointed under the plan to undertake responsibility for the development and implementation of policies and procedures relating to the plan's use and disclosure of PHI.
- **"Protected Health Information" or "PHI"** means with respect to any covered individual any information (including information of persons living or deceased) that:
    - Is created or received by the plan;
    - Relates to the past, present, or future physical or mental health or condition of the covered individual, the provision of health care to the covered individual, or the past, present or future payment for the provision of health care to the covered individual; and
    - Identifies the covered individual, or for which there is a reasonable basis to believe the information can be used to identify the covered individual.
- **"Use of PHI"** means the sharing, employment, application, utilization, examination or analysis of PHI by the City or its employees.

USE AND DISCLOSURE RESTRICTIONS

The City and its authorized employees shall use and disclose a covered individual's PHI only as prescribed below:

- Disclosures made directly to the covered individual;
- For plan administration functions, as further discussed below;

- Pursuant to the covered individual's authorization;
- For a purpose expressly permitted or required, as discussed below;
- In a manner that is incident to a permitted or required use or disclosure; or
- When required to do so by the HHS in connection with a review of the plan's compliance with the HIPAA privacy rules.

PLAN ADMINISTRATION FUNCTIONS

The City may use or disclose PHI as required to enable it to perform plan administration functions. For example, the City on behalf of the plan may provide health information to another health plan to coordinate the payment of benefits. The City may also use and disclose PHI to facilitate the administration and operation of the plan, and to provide coverage and services to all individuals covered under the plan. The City may also disclose a covered individual's PHI in the following circumstances:

- To a health care provider so as to assist in the provider's treatment activities;
- To another health plan or a health care provider for the payment activities of that other plan or provider; and
- To another health plan or a health care provider for the health care operation activities of the plan or provider, if both the plan and the other entity either have or had a relationship with the covered individual, the PHI pertains to such relationship and the disclosure is made for one of the following purposes:
    - Quality assessment and improvement activities, population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, or related functions that do not include treatment;
    - Reviewing the competence or qualifications of health care professionals, or evaluating provider or health plan performance; or
    - Health care fraud and abuse detection or compliance.

OTHER SANCTIONED DISCLOSURES

The City may use or disclose PHI in the situations prescribed below.

- The City on behalf of the plan may disclose a covered individual's PHI in response to a court or administrative order, a subpoena, warrant, discovery request or other lawful process.
- The City on behalf of the plan may disclose a covered individual's PHI if asked to do so by a law enforcement official. For example, the City may disclose health information to a police officer if needed to help find or identify a missing person.
- The City may disclose a covered individual's PHI as necessary to comply with applicable workers' compensation or similar laws.
- The City may use and disclose a covered individual's PHI when necessary to prevent a serious threat to the individual's health and safety or to the health and safety of the public or another person.

- The City may disclose PHI about a covered individual for public health activities, such as providing information to an authorized public health authority for the purpose of preventing or controlling a disease, injury or disability.
- The City may disclose a covered individual's PHI to a health oversight agency for audits, investigations, inspections and licensure necessary for the government to monitor the health care system and government programs or to ascertain compliance with applicable civil rights laws.
- The City may use or disclose a covered individual's PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.
- The City may disclose a covered individual's PHI to a coroner or medical examiner (for example, to assist in identifying the cause of a person's death).
- The City may disclose a covered individual's PHI to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- The City may disclose a covered individual's PHI to a close friend or family member involved in, or who helps pay for, the individual's health care.
- The City will disclose PHI about a covered individual when required to do so by federal, state or local law, but only to the extent of the relevant requirements of such law.

DE-IDENTIFIED INFORMATION

Health information that does not include any of the identifiers listed below with respect to any covered individual, or with respect to any relatives, employers or household members of the covered individual, is not PHI, and thus may be used or disclosed without the covered individual's authorization, but only if:

- There is no reasonable basis to believe that the information can be used to identify a covered individual; and
- The City does not have actual knowledge that the information could be used alone or in combination with other information to identify a covered individual who is the subject of the information.

The identifiers referred to above are as follows:

- Names;
- All geographic subdivisions smaller than a state, including street address, company, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:
    - The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and
    - The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000;
- All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all

elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

- Telephone numbers;
- Fax numbers;
- Electronic mail addresses;
- Social security numbers;
- Medical record numbers;
- Health plan beneficiary numbers;
- Account numbers;
- Certificate and license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;
- Web Universal Resource Locators (URLs);
- Internet Protocol (IP) address numbers;
- Biometric identifiers, including finger and voice prints;
- Full face photographic images and any comparable images; and
- Any other unique identifying number, characteristic or code.

CITY'S PRIVACY COMMITMENTS

In connection with its commitment to safeguard the privacy of the PHI of covered individuals, the City shall:

- Not use or further disclose the PHI other than as permitted or required by the plan document or as required by law;
- Ensure that its agents, including a subcontractor, to whom it provides PHI created or received by the plan agree to the same restrictions and conditions that apply to the City with respect to such information;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan maintained by the City;
- Report to the privacy official any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted under this Section of which it becomes aware;
- Pursuant to and as required under the HIPAA privacy rules:
    - Allow each covered individual access to his or her own PHI;
    - Allow covered individuals to request an amendment of their PHI; and
    - Make available to the privacy official the information necessary to provide an accounting of disclosures of PHI;
- Make the City's internal practices and records relating to the use and disclosure of PHI received from the plan available to the HHS upon request for purposes of the agency's determination of the plan's compliance with the HIPAA privacy rules; and
- Return or destroy all PHI received from the plan that the City still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or, if such return or destruction is not feasible, to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible).

EMPLOYEES WITH PHI ACCESS

The employees or other persons under the control of the City who are to have access to PHI of covered individuals are described below. The individuals so described expressly include any such employee or person who receives PHI in the ordinary course of the individual's employment or business duties:

- Risk Services Division Manager;
- Benefits Specialists;
- Risk Services Division Administrative Assistants;
- Human Resource Information System (HRIS) Manager; and
- Health and Fitness Director.

The PHI of covered individuals to be made available to the employees and other persons described above shall be restricted to the information that relates to the plan administration functions that the City performs for the plan.

The privacy official shall promptly investigate the report of any failure by an authorized employee or person to comply with the PHI privacy provisions of this Section. If the privacy official's investigation confirms the incident of noncompliance, the privacy official shall take positive reasonable action to minimize, to the extent possible, any known harmful effects resulting from the noncompliance and to assure no future noncompliance. The privacy official shall further take steps to correct, to the extent possible, known instances of harm arising from such noncompliance.

PLAN RESTRICTIONS

Notwithstanding any provision of the plan to the contrary, the plan shall:

- Disclose a covered individual's PHI to the City to carry out plan administration functions that the City performs on behalf of the plan, but only to the extent consistent with the provisions of this HIPAA Privacy Rules Section of the plan;
- Not permit a health insurance issuer or HMO with respect to the plan to disclose a covered individual's PHI to the City except as permitted by this HIPAA Privacy Rules Section of the plan;
- Not disclose and not permit a health insurance issuer or HMO to disclose a covered individual's PHI to the City as otherwise permitted by this HIPAA Privacy Rules Section of the plan, unless covered employees are provided a Notice of Privacy Practices that advises of such permissive disclosures; and
- Not disclose a covered individual's PHI to the City for the purpose of employment related actions or decisions, or in connection with any other benefit or employee benefit plan of the City.

EMPLOYEE ASSISTANCE PROGRAM

EMPLOYEE ASSISTANCE PROGRAM (EAP)

All regular, Limited Duration and Benefitted Temporary Recreation employees, their immediate families and members of the employee's household are covered by the City's Employee Assistance Program (EAP). DIRECTION for Employee Assistance, the City's EAP provider, offers confidential counseling services to assist you in finding solutions to your problems. The EAP can help you with a broad range of issues, including:

- Chemical Dependency
- Family Problems
- Relationship Concerns
- Parenting Issues
- Financial Referrals
- Work-related Problems
- Depression
- Adult Children of Alcoholics
- Grief and Loss
- Assertiveness
- Sexual Problems
- Anger Management
- Communication Skills
- Conflict Resolution
- Eating Disorders
- Physical Problems Related to Emotions

There is no charge to you for visits to the EAP. You are eligible for up to four (4) visits per problem per year. In addition, DIRECTION offers a broad range of training programs to assist employees and their family members in gaining valuable life skills. These training programs are offered at no cost and are available throughout the year. Please refer to the DIRECTION website for more information or view the current training calendar on the Human Resource and Risk Services Training Program intranet site.

DIRECTION for Employee Assistance, a service of Cascade Health Solutions, can be reached locally in Eugene at (541) 345-2800 (or 1-800-535-1347). Their office is located at 66 Club Road, Suite 120, in Eugene.

Visit the DIRECTION website at
http://www.cascadehealthsolutions.com/group/direction.html.

City of Eugene

F S A
Flexible Spending Account

&

T R A
Transportation Reimbursement Account

Revised Effective January 1, 2006

FLEXIBLE SPENDING ACCOUNT (FSA)

The City of Eugene offers employees a Flexible Spending Account Program. Take a few moments to read through the following information and learn how the program can go to work for you!

EXACTLY WHAT IS A "FLEXIBLE SPENDING ACCOUNT"?

A Flexible Spending Account (FSA) allows you to take advantage of a tax break authorized by Congress. Through the FSA Program, you can pay for certain medical, dental, vision, and dependent care expenses with before-tax dollars. Expenses must be tax-qualified--that is, allowable deductions under current IRS regulations.

By setting aside dollars under the FSA Program, you reduce the amount of your compensation that is subject to taxes. As a result, you save money through:

- ➤ Lower federal income taxes
- ➤ Lower state income taxes
- ➤ Lower FICA (social security) taxes

HOW DOES THE FSA PROGRAM WORK?

Each year you will have the opportunity to enroll in two different kinds of Flexible Spending Accounts:

- ➤ **Health Care Account.** No matter what kind of health care insurance you have, you and your family may incur costs which are not covered by your medical, dental, or vision plans. By participating in the Health Care Account, you may use before-tax dollars to reimburse yourself for these out-of-pocket costs.
- ➤ **Dependent Care Account.** Providing care for a small child, elderly relative, or other dependent while you're at work can be a financial strain. Through the Dependent Care Account, you can use before-tax dollars to reimburse yourself for day care for children under age 13 or for adult day care for a disabled spouse or other dependent.

The FSA Worksheets provided with this information will help you decide how much to set aside in an FSA. However, we encourage you to consult with your tax advisor for assistance in determining how much to contribute to a Flexible Spending Account.

PREMIUM CONVERSION PROGRAM

The City of Eugene has a Premium Conversion Program as part of our Flexible Spending Account Program. The Premium Conversion Program automatically covers all employees who are required to pay premiums for health insurance coverage under the City's group health plan by payroll deductions. The portion of the premium that you pay through payroll deductions will be deducted from your compensation on a before-tax basis; in other words, before federal and state income taxes and social security taxes are withheld. This means you will avoid paying taxes on these payroll deductions. As a result, your actual take-home pay may increase because your tax payments have been reduced.

Although the Premium Conversion Program will benefit most employees, you can opt out of this program by signing an election form indicating that you do not want your premiums to be taken on a before-tax basis. Election forms are available in Human Resource and Risk Services.

Employees who have enrolled their domestic partners in a group health plan maintained by the City are not eligible to participate in the Premium Conversion Program. The employees remain eligible to participate in the Health Care Account and Dependent Care Account aspects of the FSA Program. However, in accordance with IRS rules, qualified expenses incurred by a domestic partner (and the dependents of the domestic partner) are not eligible for reimbursement under these Flexible Spending Accounts unless the domestic partner qualifies as a dependent of the employee for federal income tax purposes.

WHO CAN PARTICIPATE IN THE FSA PROGRAM?

Non-represented employees and employees represented by the International Association of Firefighters (IAFF), the Eugene Police Employees' Association (EPEA), or the American Federation of State, County and Municipal Employees (AFSCME) who provide personal services to the City on a regular employment basis are eligible to participate in the FSA program. The program is also available to AFSCME-represented Recreation Activity Employees (RAE) and Limited Duration (LD) employees.

In addition, those members of the International Alliance of Theatrical Stage Employees (IATSE) who are eligible for City-provided health insurance benefits are also be eligible to participate in the program.

HOW CAN I PARTICIPATE IN THE FSA PROGRAM?

Participation in the FSA Program is optional. Each year you may choose to take advantage of one, both, or neither of the Flexible Spending Accounts depending on your individual needs. To participate, you must complete an enrollment form within 30 days of your employment commencement date. To continue participation, you must re-enroll prior to January 1 each year. If you have a change in status during the year, you may enroll or change enrollment amounts if the enrollment form is completed within 31 days of the change in status event.

On the enrollment form, indicate which FSA(s) you want to participate in and how much of your **before-tax** salary you want to contribute. Deposits will be made automatically from your paycheck each pay period before taxes are deducted from your gross salary. Once money is set aside into your FSA, it is not subject to federal or state income tax or payroll tax. Since your taxable income is lower, you pay less tax. The difference is extra income for you.

HOW MUCH CAN I PUT IN MY ACCOUNTS EACH YEAR?

Health Care Account. AFSCME, EPEA and IATSE-Represented employees: You are permitted to deposit $2,400 per year ($200 per month) to your Health Care Account.

All other employees: You are permitted to deposit $5,000 per year (approximately $416.66 per month) to your Health Care Account.

Dependent Care Account. You are permitted to deposit up to $5,000 per year to your Dependent Care Account.

However, you are cautioned to be careful in regard to the amount which you elect to have set aside in your Flexible Spending Accounts. The primary reason for this caution is the "use it or lose it rule" imposed by the IRS.

"USE IT OR LOSE IT," WHAT DOES THAT MEAN?

By law, any remaining unused funds in your Flexible Spending Accounts are forfeited at the end of the year — you must "use it or lose it." That is why it is important to be conservative when determining how much to put into your FSA each year. You can carry balances from your Accounts forward from month to month, but you cannot carry over to the next year any money remaining in your Accounts as of the end of the year, except as provided under the "Grace Period", which is explained below.

WHAT IS THE HEALTHCARE FSA PLAN YEAR GRACE PERIOD?

The IRS has allowed an increase in the number of days you can incur services under your Healthcare FSA account. (The grace period does not apply to Dependent Care accounts.) You will have an additional 2½ months after the end of the plan year to incur healthcare expenses that can be submitted for reimbursement to your Healthcare FSA under the prior year's account. This gives you more time to exhaust any funds you may have left at the end of the year. You will have an additional 90 days after the end of the grace period to submit claims for the previous plan year.

DO ANY OTHER SPECIAL GUIDELINES APPLY?

Yes. In order to provide you tax savings, the IRS has imposed several important restrictions on Flexible Spending Accounts:

- ➤ Each Account must remain separate. In other words, money in your Health Care Account cannot be used to pay dependent day care expenses, nor can money in your Dependent Care Account be used to pay for health care expenses.
- ➤ You must elect the total amount to deposit for a year before the start of each year. The amount you elect remains in effect for the rest of the year unless you have a qualified change in status.
- ➤ Health care expenses reimbursed through the Health Care Account cannot also be claimed as a deduction on your personal income tax return. In addition, the amount of expenses which may be claimed for the dependent care tax credit will be reduced, dollar for dollar, by the amount of expenses reimbursed through the Dependent Care Account.

WHEN CAN I CHANGE MY FSA ELECTIONS?

You may change the amount you deposit into your Flexible Spending Accounts when you re-enroll prior to January 1 each year. Normally, once you begin depositing before-tax salary into your Flexible Spending Accounts, that contribution election must remain in effect for the rest of the calendar year

(January 1 through December 31). In other words, you generally will not be able to modify or revoke your election during a year. The same rule applies to your election not to participate in the FSA Program for a year. In that case, you generally cannot enroll until the following year.

An exception to this general rule applies if you incur what the IRS rules refer to as a "**change in status**." Under this exception, you may modify or revoke an election for a year, or elect to enroll in the FSA Program for the remainder of the year, if you, or your spouse or dependent, incurs such a change in status. However, the modification, revocation or enrollment election must be consistent with and on account of the change in status.

The form for requesting a change in election by reason of a change in status event is available from Human Resource and Risk Services. The form must be submitted to Human Resource and Risk Services within 31 days of the applicable event.

WHAT IS A 'CHANGE IN STATUS" EVENT?

For purposes of the Premium Conversion Program and the Health Care Account, the "change in status" events which may allow you to change your FSA election for a year are as follows:

- An event that changes your legal marital status, including marriage, death of your spouse, divorce, legal separation, or annulment;
- An event that changes the number of your dependents, including the birth, adoption, placement for adoption, or death of a dependent;
- The commencement or termination of employment;
- The change in employment status, such as a transfer between part-time and full-time employment status;
- The commencement of or return from an unpaid leave of absence or leave governed by the Family and Medical Leave Act (FMLA);
- An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage under the City's group health plan due to attainment of age, student status, or similar circumstance;
- A change in work location or residence;
- A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that obligates you to provide group health coverage for your child, or which releases you from such an obligation;
- Enrollment in Medicare (Part A or Part B);
- Any other event which Human Resource and Risk Services determines will permit the making, changing or revocation of any election during a year pursuant to regulations and rulings issued by the IRS.

Under the IRS rules, a change in election in regard to the Premium Conversion Program or the Health Care Account by reason of a change in status event will be permitted only if the event affects the coverage of you, your spouse or your dependent under the City's group health plan or another employer-sponsored group health plan.

With respect to the Dependent Care Account, you can modify or revoke your election during a year, or elect to enroll in the program for the remainder of a year, under one of the following circumstances:

- You incur a change in status described above which causes you to incur, or cease to incur, qualified dependent care expenses, such as a child attaining age 13 and thus ceasing to be a "qualifying individual";
- A change in the cost of the dependent care expenses due to a change in the dependent care provider or in the amount of care provided, such as a decrease in the hours of care upon the child's commencement of school;
- An increase in the amount charged by the dependent care provider (but only if the provider is not a member of the employee's family or household); or
- Any other situation which Human Resource and Risk Services determines will permit enrolling in, or modifying or revoking an election under, the Dependent Care Account during the year.

If you revoke a contribution election with respect to the Health Care Account or the Dependent Care Account during a year (other than in connection with your leaving employment), you will not be deemed to have revoked your participation in the program for the year. Instead, you will be deemed to have changed the amount of your total contribution for the year to equal the contributions made under the applicable FSA Program through the effective date of the revocation. You will continue to be eligible for reimbursements under the FSA Program for the remainder of the year, even though no further contributions are being made.

You should contact Human Resource and Risk Services if you have questions as to whether a particular event will allow you to make, change or revoke an FSA Program election during a year.

WHO ARE YOUR QUALIFIED DEPENDENTS?

Expenses are reimbursable from the FSA Program only if they are qualified expenses that are incurred by you, your legal spouse or your qualified dependents.

In general, a qualified dependent for any year means any of the following individuals if more than one-half of the individual's financial support for the year is provided by you (or, if you are married, by you and your spouse):

- A son or daughter, or a descendant of either;
- A stepson or stepdaughter;
- A brother, sister, stepbrother, or stepsister;
- A father or mother, or an ancestor of either;
- A stepfather or stepmother;
- A son or daughter of a brother or sister;
- A brother or sister of the father or mother;
- A son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law;
- Any other individual who resides with you and is a member of your household.

For purposes of the Health Care Account, a child of a divorced employee will be treated as a dependent of an employee for a year if more than one-half of the child's support for the year is provided on a combined basis by both divorced parents. This dependent status rule will apply even if the employee is not the custodial parent with respect to the child or is otherwise not eligible to claim a personal exemption deduction with respect to such child for income tax purposes.

For purposes of the Dependent Care Account, a child of a divorced employee will be treated as a dependent of an employee for a year only if the employee has custody of the child for a longer period during the year than the other parent, regardless of whether the employee is otherwise eligible to claim a dependency exemption deduction with respect to such child for income tax purposes.

The IRS does not recognize an employee's domestic partner as being a qualified dependent for tax purposes (unless the employee provides more than one-half of the domestic partner's financial support). Accordingly, expenses incurred by a domestic partner (or the dependents of a domestic partner) generally are not reimbursable under the FSA Program.

WHAT ARE "QUALIFIED" HEALTH CARE EXPENSES?

Your Health Care Account can be used to pay for medical, dental, and vision expenses for you and your qualified dependents which are not covered by the City's group health plan (or any other group health care plan), and which are considered qualified medical expenses by the IRS.

These expenses include:

- ➤ Expenses which are covered under your group health plan, but which are not reimbursable because of the annual deductible and co-payment provisions of the plan;
- ➤ Qualified medical expenses which are not covered under the group health plan, including Over-the-Counter (OTC) products if the OTC product is for medical care and primarily for a medical purpose. For information regarding expenses that are eligible for reimbursement, contact BenefitHelp Solutions Member Services at 1-888-398-8057.

WHAT ARE QUALIFIED DEPENDENT CARE EXPENSES?

Typically, these include the dependent care expenses listed below as long as the day care is needed so you can work:

- ➤ Day care provided by individuals who care for young children up to age 13 in or outside the home;
- ➤ Preschool and day-care centers as long as they comply with State and local government laws and regulations, provide care for more than six individuals who do not live at the center, and receive payment for services;
- ➤ Programs for children up to age 13 while schools are not in session;
- ➤ Special care for mentally or physically handicapped dependents;

- ➤ Home care, non-medical nursing, or nurse's aid services for a dependent parent who lives with you (medical care falls under health care expenses); and
- ➤Dependent care centers which provide day care for adults, not residential care.

WHAT ARE OTHER DEPENDENT CARE ACCOUNT CONCERNS?

In addition to the "use it or lose it" rule discussed earlier, you should be aware of two other factors before you elect to have amounts set aside in your Dependent Care Account.

The first relates to the limitations on the amount of reimbursements from that Account which will ultimately be exempt from income taxation. More specifically, the maximum amount of reimbursements from your Dependent Care Account which you can exclude from income for any year is the least of the following amounts:

- ➤ $5,000 ($2,500 if you are married but file a separate federal income tax return);
- ➤ The amount of your taxable wages for the year; or
- ➤ If you are married, your spouse's actual or deemed earned income for the year.

For purposes of the third factor above, your spouse, if not employed, will be deemed to have earned income for any month during a calendar year in which he or she is either physically or mentally incapable of self-care, or is a full-time student during at least five calendar months during that year. The amount of such deemed earned income for each such month is $200 if you have one minor child or other individual qualifying for dependent care coverage, and $400 per month if you have two or more qualifying individuals.

You should keep the above statutory limits in mind when calculating the amount you wish to have set aside in your Dependent Care Account for a year.

The second consideration is the federal and Oregon dependent care tax credits which are also available to employees. Most employees will realize greater tax savings by participating in the Dependent Care Account. However, certain employees may be better off not participating in the Dependent Care Account program so as to be eligible for the dependent care tax credits.

WHAT HAPPENS IF I LEAVE EMPLOYMENT DURING A YEAR?

For AFSCME, EPEA and IATSE-Represented employees: If you have elected to set aside monies to a Health Care Account or Dependent Care Account for a year and you leave employment during the year, your participation in the FSA Program will be terminated. In that event, you will be eligible for reimbursements from your Health Care or Dependent Care Accounts only for expenses incurred before your termination of employment. In addition, you have the option of electing to continue your participation in the Health Care FSA for the remainder of the year by submitting the required monthly premium amount to Human Resource and Risk Services by the first of each month. Contact Human Resource and Risk Services for details about continuing your Health Care FSA benefits.

If you become reemployed with the City within 30 days of your termination, then your prior FSA elections will be automatically reinstated. If you resume employment more than 30 days following your termination, you will be permitted to make a new FSA election for the remainder of the year.

For all other eligible employees: If you have elected to set aside monies to a Health Care Account for a year and you leave employment during the year, the remaining monthly contribution will be taken from your final paycheck on a pre-tax basis; or you may agree to reimburse the City on a monthly basis with after-tax dollars. Exceptions to this policy are made in the event of death, disability or involuntary termination. You will remain a participant in the Health Care FSA program through the end of the Plan Year and will have until the end of the year to incur eligible expenses.

WHAT HAPPENS IF I TAKE A LEAVE OF ABSENCE?

Your treatment under the FSA Program upon the taking of a leave of absence depends upon the particular type of leave. (*Note that you cannot receive reimbursements for Dependent Care expenses incurred during a leave of absence period from the City, unless you need child care so you can work.*)

- If you take a paid leave of absence, your participation under the FSA Program will continue on the same basis as if you were otherwise actively employed by the City.
- If you take an unpaid leave of absence that is not covered under the Federal Family and Medical Leave Act (FMLA), then in order to continue participation under the program, you must submit the required premium amount to Human Resource and Risk Services by the first of each month. You may also pre-pay the premiums that will become due during the leave period and within the year in which the leave commences. This pre-payment may be made by increasing, to the extent required, the amount of your premium payroll deduction for the pay period (or pay periods) preceding the period of your unpaid leave. If you do not pre-pay or otherwise remit the required premium by the 30th day of the month, then your participation will be revoked retroactive to the first day of the month, and you will not be permitted to resume participation during the remainder of that year.
- If you take unpaid FMLA leave, you may continue participation under the FSA Programs by pre-paying or otherwise timely remitting the required premium each month as generally described above. You may alternatively elect to suspend participation during the period of your FMLA leave. However, no expenses incurred by you during the period of suspension will be reimbursable under the FSA Program.

  If you elect to suspend your participation during the FMLA leave period, or if your participation during such period is revoked because you failed to timely pay the required premium, then you may elect to resume such participation upon returning from the FMLA leave. In that event, you can choose to pay the same monthly amount as you were paying prior to the taking of the FMLA leave. If you make this choice, the total amount reimbursable from your Health Care Account and Dependent Care Account for the year will be reduced to take into account the period of FMLA leave for which no premiums were paid.

For example, if you were contributing $100 per month ($1,200 for the year) to your Health Care Account, and you took one month of unpaid FMLA leave for which you did not make your usual $100 premium payment, then upon your return, you can elect to continue making premium payments in the amount of $100 per month. However, your reimbursement limit for the year will be reduced from $1,200 to $1,100.

Upon returning from unpaid FMLA leave, you may also instead choose to have reinstated the full reimbursement amount for the year as elected and in effect prior to the FMLA leave (e.g., $1,200 using the above example). In that event, your monthly premiums for the remainder of the year will be increased as necessary to make up for the premiums that had not been paid during the FMLA period.

In all regards, while you are on FMLA leave, you will have the same election rights under the FSA Programs as available to employees who are not on FMLA leave.

HOW DO I REQUEST REIMBURSEMENT FROM MY FSA?

Flexible Spending Account Claim Forms, complete with instructions, are available on the Employee Benefits website at www.eugene-or.gov/HRRS (navigate to Employee Benefits/Benefit Forms).

- If you sign up for Direct Deposit, reimbursement from your FSA will be automatically deposited into your bank account. Otherwise, BenefitHelp Solutions will send you a check for the reimbursement amount.
- If you enroll in AutoPay, out-of-pocket expenses for claims submitted to ODS will be automatically reimbursed from BenefitHelp Solutions, either with a check or through Direct Deposit. An FSA claim form is not required if claim is billed through your insurance.
- When you have an eligible expense that is not reimbursed through AutoPay, first pay the bill or submit insurance claims for the services and follow the steps below:
  - Complete a Flexible Spending Account Claim Form, available on the Employee Benefits website at www.eugene-or.gov/HRRS or from Human Resource and Risk Services.
  - Attach to the form proof of your expenses - either an Itemized Bill from your medical provider (indicating patient's name, name of the medical provider, and amount of expenses incurred), an Explanation of Benefits (EOB) from your insurer, or a Statement of Services from your dependent care provider indicating the name and the date(s) of service, and the amount of the incurred expense.
- Requests for reimbursement can be made at any time as long as the accumulated expenses equal at least $25 (several small claims equaling $25 may be filed together). During the last three months of the calendar year and at termination of employment, claims of any dollar amount may be submitted. You will be reimbursed from your Account(s) after BenefitHelp Solutions (BHS) has received your FSA Claim Form and processed your check. Your reimbursement checks will be mailed to your home address. Or, you may have your reimbursement funds directly deposited into a checking or savings account.

- ➤ For Orthodontia claims, BHS requires a copy of the signed contract between you and the Orthodontist. The City of Eugene's Health Care FSA Plan allows for "up-front" reimbursements for orthodontia.
- ➤ The maximum reimbursement for dependent care expenses as of any time is limited to your current Dependent Care Account balance. For example, if you submit a claim for $100 and there is only $50 in your account, you will then be reimbursed only $50 and the balance will be paid as money accumulates in your account.
- ➤ For a Dependent Care FSA, only the current year's expenses can be reimbursed from your Account. However, you have until March 31 of the following calendar year to submit requests for reimbursement of expenses which you incurred during the previous plan year.
- ➤ For a Healthcare FSA, you can submit expenses incurred during the 2½ month grace period (through March 15) to either the current plan year or the previous plan year. You have until June 15 of the following year to submit claims to the previous year's account.
  - For example: You still have funds left in your 2005 Healthcare FSA account and have a doctor's appointment on March 1, 2006. You would have until June 15, 2006 to submit the claim for reimbursement from the 2005 plan year.
- ➤ Return your Flexible Spending Account Claim Form to:

  BenefitHelp Solutions (BHS)
  ATTN: FSA
  PO Box 67230
  Portland OR 97268-1230
  The FSA Group Plan Number is: 8656

- ➤ If you have any questions regarding the Flexible Spending Account, you can call BHS at 1-888-398-8057 between 8:00 am and 5:00 pm, Monday through Friday.

MUST I REPORT MY REIMBURSEMENTS ON MY TAX RETURN?

You do not need to report reimbursements that you receive from your Health Care Account on your federal income tax return. However, because the monies which you contributed to this Account were made on a tax-favored basis, you also cannot claim these contributions as a medical expense deduction on your personal income tax return.

If you receive reimbursement from your Dependent Care Account for a year, you must report the amount of such reimbursements on your IRS income tax return. To assist you in completing the IRS forms, the Form W-2 which we provide you following the end of each year will disclose the amount of reimbursements actually paid to you during the year.

WHAT IF MY REIMBURSEMENT REQUEST IS DENIED?

If BenefitHelp Solutions determines that your reimbursement request is to be denied in whole or in part, it will provide you with a written notification of such denial. You may appeal that denial by submitting a written request for review to BenefitHelp Solutions within 180 days of the notice that the claim was denied. If you do not appeal within this time frame you will lose the right to appeal.

A written appeal should state the reasons that the claim should not have been denied and should include any additional facts and/or documents that support the claim. The decision regarding the appeal will be made no later than 60 days after submission of the appeal. This review will be independent of the initial reimbursement request denial.

You will be provided with written notification of the decision regarding the appeal of your reimbursement request denial. If your appeal is to be denied in whole or in part, the notice will include the following:

- ➤ The specific reason or reasons for the appeal denial; and
- ➤ Reference to the specific plan provisions upon which the appeal denial is based.

HEALTH CARE ACCOUNT WORKSHEET

The following worksheet can help you estimate your eligible health care expenses and how much, if any, to contribute to a Health Care Account. First, list out-of-pocket medical, dental, and vision care expenses you and your dependents will have incurred this year. Next, try to estimate what health care expenses both you and/or your dependents may have next year (from January 1st through December 31st) by making a comparison to this year's expenses.

Remember generally, if a health care expense is deductible for Federal income tax purposes, it is considered "qualified" for reimbursement under your Health Care Account.

	THIS YEAR'S EXPENSES	NEXT YEAR'S ESTIMATED EXPENSES
Medical, Dental, Vision Deductibles	$	$
Medical, Dental, Vision Co-payments	$	$
Prescription Drug Co-payments	$	$
Non-Prescription Drugs and Medications	$	$
Other Medical Services Not Covered	$	$
Denture Replacements	$	$
Other Dental Services Not Covered	$	$
Replacement of Glasses/Lenses/Frames	$	$
Laser Refractive Eye Surgery	$	$
Other Vision Services Not Covered	$	$
Total Estimated Annual Expenses	**$**	**$**

Total your estimated expenses for the upcoming plan year (if enrolling mid-year, estimate expenses from your enrollment date to the end of the plan year). That number is a suggested amount that you may want to contribute to the Health Care Account. Remember, be conservative — unused money will be forfeited as required by IRS regulations.

DEPENDENT CARE ACCOUNT WORKSHEET

The following worksheet can help you estimate your eligible dependent care expenses and how much, if any, to contribute to a Dependent Care Account. First, list out-of-pocket dependent care expenses you have incurred this year. Next, try to estimate what dependent care expenses you may have next year (from January 1st through December 31st) by making a comparison to this year's expenses.

	THIS YEAR'S EXPENSES	NEXT YEAR'S ESTIMATED EXPENSES
Pre-school or day care expenses	$	$
Babysitting in or outside your home (while you are at work)	$	$
Other non-educational programs to care for children when school is out	$	$
Non-medical home care or nursing for a dependent parent or handicapped child	$	$
Total Estimated Annual Expenses	**$**	**$**

Total your estimated expenses for the upcoming plan year (if enrolling mid-year, estimate expenses from your enrollment date to the end of the plan year). That number is a suggested amount that you may want to contribute to the Health Care Account. Remember, be conservative - unused money will be forfeited as required by IRS regulations.

Also remember, your total reimbursements for the year cannot exceed the least of:

- ➤ Your income; or
- ➤ If you are married, your spouse's income; or
- ➤ $5,000 ($2,500 if married and will file separate tax return)

TRANSPORTATION REIMBURSEMENT ACCOUNT (TRA)

PROGRAM SUMMARY

The City of Eugene's Transportation Reimbursement Account (TRA) program is similar to the City's Flexible Spending Account program and is administered by BenefitHelp Solutions. This program is allowed under the Transportation Equity Act for the 21st Century (TEA 21), is regulated by Internal Revenue Service Code § 132(f) and is officially known as the Commute Expense Reimbursement Account (CERA) program. Employees who pay to commute to work have the opportunity to set aside a portion of their salary to pay for certain qualified transportation expenses without being taxed on these amounts.

When you participate in this program, the contributions you make to your TRA will be deducted from your compensation on a before tax basis; before state, federal, and social security taxes are withheld. This means you will avoid paying taxes on these deductions.

Please review the following information before you make your decision to participate in this program. If you have additional questions or need assistance, please contact Human Resource and Risk Services at 682-8868.

ELIGIBILITY

All regular employees are eligible to participate in this program. In addition, AFSCME-represented Limited Duration and Recreation Activity Employees (RAEs) and IATSE-represented employees who are eligible for City-provided health insurance benefits are eligible to participate in the program.

HOW TO ENROLL IN A TRA

Open enrollment is held annually in December of each year. Your TRA account will be effective the first of the month following the completion of the Participation Agreement. New employees must enroll within 31 days of their date of hire.

IMPORTANT NOTE: Employees who park in City parking lots and pay a payroll deduction for parking will *automatically* be enrolled in the TRA program and will not have to fill out an enrollment form unless they intend to participate in the Van Pool or Mass Transit features of the program. Although the pre-tax payroll deduction will benefit most employees, you can opt out of this program by signing an election form indicating that you do not want your parking fees to be taken on a before-tax basis. Election forms are available in Human Resource and Risk Services.

PARTICIPATION AGREEMENT CHANGES

The Participation Agreement may be revoked or changed at any time, effective the first of the following month. The employee's Participation Agreement ends upon termination of employment.

QUALIFIED TRANSPORTATION EXPENSE

Expenses incurred by the employee to purchase or pay for transit pass expenses, commuter vehicle expenses (van pools), or qualified parking expenses incurred for the purpose of transportation between an employee's residence and place of employment or for parking in conjunction with use of mass transit or van pool qualifies as a transportation expense.

Mass transit is a public system or private enterprise provided by a company/individual who is in the business of transporting people in a commuter highway vehicle, i.e., buses. Such vehicle must have a seating capacity of six or more adults (not including the driver) and at least 80 percent of the vehicle's mileage must be from transporting individuals to and from their place of work. The vehicle must be carrying at least three passengers (not including the driver). This does not include car pooling.

Mass transportation includes transit passes for mass transportation to and from work. Qualified amounts include costs of any pass, token, fare card, voucher, or other item that entitles the employee to use mass transit for the purpose of traveling to or from his/her place of work.

Van pool means that the vehicle must seat at least six adults **plus** a driver and be used at least 80 percent of the time to commute between home and work. Expenses incurred for transportation in a van pool are eligible provided such transportation is in connection with travel between the individual's residence or park-and-ride lots and place of employment.

Parking expenses are fees for parking at or near your primary work location, the location where you take mass transit, or the location where you pick up the van pool. Only the expense of parking the vehicle is a covered expense through TRA. Fuel, maintenance, and insurance costs are not covered.

TRA CONTRIBUTION LIMITATIONS

(Subject to change by the IRS)

Transportation Reimbursement Account	Per Month
Parking	**$205**
Transit Pass and Van Pooling (combined)*	**$105**

*The Transit Pass maximum contribution amount will be reduced by the value of the bus pass purchased for employees by the City.

REIMBURSEMENT

Complete the claim form available through Human Resource and Risk Services. Submit the claim form and receipt(s) to:

BenefitHelp Solutions (BHS)
ATTN: FSA
PO Box 67230
Portland OR 97268-1230

If you have questions about your Transportation Reimbursement Account, please feel free to contact BHS toll-free at 1-888-398-8057.

City of Eugene

L T D
Long-Term Disability Insurance

Revised January 2005

LONG-TERM DISABILITY

The City of Eugene Long-Term Disability (LTD) Plan provides you with income protection if you become disabled from a physical disease, mental disorder, accidental bodily injury or pregnancy.

The monthly LTD benefit varies by pay unit. Your benefit will be at least $50 per month, but not more than the maximum listed on page 100. LTD benefits are payable after the end of the Benefit Waiting Period. This LTD insurance covers only you, not your dependents. Insurance is provided through Standard Insurance Company of Portland, Oregon.

ELIGIBILITY

As a regular or Limited Duration employee scheduled to work at least 20 hours per week (or one-half of the hours in a pay period for AFSCME-represented employees), you are eligible for long-term disability insurance coverage. Eligibility for IATSE-represented and AFSCME-represented Benefitted Temporary Recreation (BTR) employees is specified in the most recent labor agreement between the City of Eugene and the unions.

WHEN COVERAGE BEGINS

For all groups except IATSE-represented and AFSCME-represented Benefitted Temporary recreation (BTR) employees, LTD coverage begins on the first day of the month following your first day of active employment as an eligible employee.

For IATSE-represented and AFSCME-represented BTR employees, LTD coverage begins on the first day of the month following your first day of eligibility as specified in the current labor agreement between the City of Eugene and the unions.

All employees must meet the Active Work Requirement before insurance will become effective.

ACTIVE WORK REQUIREMENT

If you are incapable of Active Work because of physical disease, mental disorder, injury or pregnancy on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of Active Work as an eligible employee.

Active Work means you are performing the material duties of your own occupation at your employer's usual place of business. The Active Work Requirement also applies to any increases in your insurance.

WHEN COVERAGE ENDS

LTD coverage ends automatically on the earliest of: the following dates:

- The date the Group Policy terminates.
- The date your employment with the City terminates.
- The last day of the calendar month in which you cease to be eligible for coverage under the LTD plan. However, if you cease to be otherwise eligible for coverage because you are not working the required minimum number of hours, your insurance will be continued during the following periods, unless it ends because of one of the other events described.
    - While the City is paying you at least the same pre-disability earnings paid to you immediately before you ceased to be eligible for coverage.
    - During the Benefit Waiting Period and while LTD benefits are payable.
    - During a leave of absence if continuation of your insurance under the Group Policy is required by a state-mandated family or medical leave act or law.
    - During any other leave of absence approved in advance and in writing by the City and scheduled to last through the last day of the calendar month in which the City ceases to pay you the full amount of your pre-disability earnings.

HOW TO ENROLL

You are automatically covered for LTD insurance benefits based on your eligibility. No action on your part is required to enroll.

DEFINITION OF DISABILITY

You are considered disabled from your own occupation if, as a result of physical disease, mental disorder, injury or pregnancy, you are not able to perform with reasonable continuity the material duties of your own occupation. **Medical certification of disability is required.**

Until LTD benefits have been paid for 24 months, you are required to be disabled only from your own occupation. After LTD benefits have been paid for 24 months, you must be disabled from all occupations in order to continue receiving benefits. You are disabled from all occupations if, as a result of physical disease, mental disorder, injury or pregnancy, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.

BENEFIT WAITING PERIOD

The Benefit Waiting Period is the time you must be continuously disabled before you are eligible for LTD benefits. If you are an AFSCME-represented employee, your Benefit Waiting Period is the longer of:

- 90 days of continuous disability, or
- the period for which you are eligible for sick leave pay, whichever is longer.

For all other employee groups, your Benefit Waiting Period is the first 90 days of continuous disability. Your Benefit Waiting Period begins on the date you become disabled. You must be seen regularly and be treated by a physician during the Benefit Waiting Period.

LTD Benefits begin at the end of the Benefit Waiting Period. LTD Benefits end on the earliest of:

- The day of your death;
- The day your disability no longer exists;
- The end of the Maximum Benefit Period; or
- The day benefits become payable to you under any other group long-term disability policy.

MAXIMUM BENEFIT PERIOD

The **Maximum Benefit Period** is the longest period of time LTD benefits are payable for any one period of continuous disability, whether from one or more causes. Your Maximum Benefit Period is determined as follows:

AGE WHEN DISABILITY BEGINS	MAXIMUM BENEFIT PERIOD
61 or younger	To age 65
62	3 years, 6 months
63	3 years
64	2 years, 6 months
65	2 years
66	1 year, 9 months
67	1 year, 6 months
68	1 year, 3 months
69 or older	1 year

Your Maximum Benefit Period ***begins*** at the end of the Benefit Waiting Period. During the Maximum Benefit Period, LTD benefits are paid at the end of each monthly period for which you qualify for LTD benefits. LTD benefits will stop at your death or at any time during the Maximum Benefit Period when you no longer qualify for LTD benefits.

LTD benefits will stop at the end of the Maximum Benefit Period even if you are still disabled.

EXCEPTION FOR MENTAL DISORDERS: Payment of LTD benefits is limited to 24 months for each period of disability caused or contributed to by a mental disorder. However, if you are confined in a hospital at the end of the 24 months, this limitation will not apply while you are continuously confined.

AMOUNT OF BENEFIT

After the Benefit Waiting Period, the LTD Plan provides for a total monthly benefit, including Deductible Income, equal to 60% (66% for EPEA-represented employees) of your basic monthly pay up to a maximum amount. Basic monthly pay equals your monthly rate of earnings, excluding bonuses, overtime pay, commissions and any other extra compensation.

PAY UNIT	BENEFIT
AFSCME*	60% of your first $4,000 basic monthly pay ($2,400/month maximum benefit)
Non-Represented	60% of your first $5,000 basic monthly pay ($3,000/month maximum benefit)
IAFF	60% of your first $5,000 basic monthly pay ($3,000/month maximum benefit)
EPEA	66% of your first $5,000 basic monthly pay ($3,300/month maximum benefit)
IATSE	60% of your first $5,000 basic monthly pay ($3,000/month maximum benefit)

* The long term disability benefit for Benefitted Temporary Recreation employees will be based on the standard hours designated in the payroll system.

DEDUCTIBLE INCOME

If you become disabled, the amount of your LTD Benefit payable under the plan will be reduced by the following Deductible Income:

- Any income paid as salary, wages or other payment by the City of Eugene or any other employer, except as provided under an approved rehabilitation program.
- Any sick pay or other salary continuation paid to you by the City of Eugene, not including vacation pay.
- Any amount you receive or are eligible to receive under Worker's Compensation Law or other similar legislation.
- Any state disability plan benefits.
- Any amount you, your spouse or your children under age 18 are eligible to receive because of your disability or retirement under the Federal Social Security Act, or any similar plan, act or law.
- Any disability benefits you are eligible to receive because of your disability under any other group insurance plan or under a plan arranged and maintained by a union or employee association.
- Any benefits you are eligible to receive under the City of Eugene’s retirement plan (PERS).
- Any amount received by compromise, settlement or other method as a result of a claim for any of the above.

When income benefits are not payable from any of these sources, the entire amount of the guaranteed monthly income will be paid by the plan. When part of the guaranteed monthly income is payable from one or more of these sources, the balance will be paid by the plan.

In all cases, the LTD Plan will pay a minimum monthly benefit of $50. Your LTD benefit during a period of disability will be determined by your maximum monthly pay in effect on your last day of active work before you became disabled.

It is your responsibility to make timely claims for any Deductible Income to which you may be entitled. Otherwise, the benefits from this plan can be reduced by the amount it is reasonable to believe would have become a reduction had you pursued Deductible Income in a timely manner.

You must cooperate in providing necessary information. If, as a result of the annual adjustment or amendment to the Social Security Law, Social Security benefits are increased while you are receiving benefits under this plan, such a Social Security increase will be an extra benefit, and will not be considered Deductible Income.

The following are ***not*** considered Deductible Income:

- Any cost of living increase in any Deductible Income. The increase must be effective while you are disabled and are eligible to receive the Deductible Income. (This exception does not apply to any increase in your earnings from any work.)
- Amounts you receive as reimbursement for medical expenses.
- Reasonable attorney's fees incurred in connection with your claim for Deductible Income.
- Benefits from an individual disability insurance policy.
- Early retirement benefits under the Federal Social Security Act which are not actually received.
- Group credit or mortgage disability benefits.
- Accelerated death benefits paid under a life insurance policy.
- Benefits from a deferred compensation plan or IRA.

TEMPORARY RECOVERY

If, after LTD benefits become payable, you have more than one period of disability because of the same condition, these periods will be considered one period of disability if separated by a period of recovery of 180 days or less. However, if you work for six or more months between periods of disability, the new period will not be considered part of the earlier period. No benefits will be payable under this provision after benefits become payable to you under any other group LTD insurance policy.

EXCLUSIONS AND LIMITATIONS

Disability income is not payable if your disability is caused by or is a direct result of:

- War or any act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.
- Intentionally self-inflected injury, while sane or insane.

No LTD benefits will be paid for any period disability when you are not under regular care of a physician.

Payment of LTD benefits is limited to 24 months for each period of disability caused on contributed to by a mental disorder. However, if you are a resident patient in a hospital at the end of the 24 months, this limitation will not apply while you remain continuously confined.

APPLYING FOR BENEFITS

You must claim LTD benefits within 90 days after the end of the Benefit Waiting Period, or as soon as possible thereafter, but not later than one year after that 90 day period. Claims not filed with Standard Insurance Company within these limits may be denied.

After Standard Insurance Company receives your claim, you will receive a written decision within a reasonable amount of time. If you do not receive this decision within 90 days after your claim is received, you have the right to request a review.

All claim forms are available from Human Resource and Risk Services, which can also provide you with information regarding claims procedures.

ACCIDENTAL LOSSES

Your LTD coverage provides a Minimum Benefit Period if you suffer one of the accidental losses shown in the following table:

Accidental Loss	Minimum Benefit Period
Both Hands or Feet or Sight of Both Eyes	5 years
One Hand and One Foot	5 years
Either One Hand or Foot and Sight of One Eye	5 years
Either Hand or Foot	6 months
Sight of One Eye	6 months

Loss of hand or foot means permanent severance of the hand or foot from the body at or above the wrist or ankle joint; loss of sight of any eye means entire and irrecoverable loss of sight. The

loss must be caused solely and directly by an accident, occur independently of all other causes, and occur within 180 days after the accident.

You will receive LTD benefits for the applicable Minimum Benefit Period, subject to certain exclusions. Consult Human Resource and Risk Services or the prior pages of this booklet for a complete listing of exclusions or additional information.

REHABILITATION EMPLOYMENT

The disability program features a Rehabilitation Program that encourages you to return to work. Under this program, you may work while LTD benefits are payable provided you are considered to be disabled. During the first year you are working, LTD Benefits will be reduced by your work earnings to the extent that your work earnings exceed 100% of your pre-disability earnings when added to your LTD Benefit. Thereafter, 50% of your work earnings will be deducted from your LTD Benefits.

NOTE: All or part of the Benefit Waiting Period can be satisfied while you are working if you are considered disabled during your period of work activity.

The Rehabilitation Program does not force you to return to work; it only encourages you to do so, as long as you have your doctor's permission.

City of Eugene

LIFE INSURANCE

LIFE INSURANCE

The City of Eugene Life Insurance Plan, through Standard Insurance Company, offers financial protection for your family. It provides you with two types of benefits: Basic Life Insurance and Accidental Death and Dismemberment (AD&D) Coverage.

ELIGIBILITY

As a regular or Limited Duration employee scheduled to work at least 20 hours per week, you are eligible for the basic life insurance and AD&D insurance coverage. Eligibility for regular IATSE-represented and AFSCME-represented Benefitted Temporary Recreation (BTR) employees is specified in the most recent labor agreement between the City of Eugene and the unions.

WHEN COVERAGE BEGINS

Your basic life insurance and AD&D coverage begins on the first of the month following your first day of continuous service. For IATSE-represented and AFSCME-represented BTR employees, coverage begins on the first of the month following your eligibility date.

All employees must meet the Active Work Requirement before insurance will become effective.

ACTIVE WORK REQUIREMENT

If you are incapable of Active Work because of sickness, injury or pregnancy on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of Active Work as an eligible employee.

Active Work means you are performing the material duties of your own occupation at your employer's usual place of business. The Active Work Requirement also applies to any increases in your insurance.

WHEN COVERAGE ENDS

Your basic life insurance and AD&D coverage ends automatically on the earliest of the following dates:

- The date the Group Policy terminates;
- The last day of the calendar month in which your employment with the City terminates; and
- The last day of the calendar month in which you cease to be eligible for coverage under the Life Insurance Plan.

However, if you cease to be otherwise eligible for coverage under the Life Insurance Plan because you are no longer working the required minimum number of hours, then your Life Insurance will be continued with premium payment during the following periods, unless your insurance ends due to one of the other events described.

- While the City is paying you at least the same annual earnings paid to you immediately before you ceased to be eligible for coverage.
- While your ability to work is limited because of sickness, injury or pregnancy.
- During the first 60 days of:
  - A temporary layoff; or
  - A strike, lockout, or other general work stoppage caused by a labor dispute between your collective bargaining unit and the City.
- During a leave of absence if continuation of your insurance under the Group Policy is required by a state-mandated family or medical leave act or law.
- During any other leave of absence approved by the City in advance and in writing and scheduled to last through the last day of the calendar month in which the City ceases to pay you the full amount of your annual earnings.

Your AD&D coverage ends on the date your claim for continued life insurance is approved by Standard Insurance Company.

HOW TO ENROLL

To enroll in the plan, you must complete a form designating your beneficiary and return it to Human Resource and Risk Services.

DESIGNATING YOUR BENEFICIARY

In the event of your death while you are a covered employee, your designated beneficiary or beneficiaries will receive your insurance benefit. If you indicate more than one beneficiary, you may specify the percentage to be paid to each person at your death. You may also indicate a primary beneficiary and a contingent beneficiary. The contingent beneficiary will only receive benefits in the event that the primary beneficiary predeceases you.

If you do not name a beneficiary, or if you are not survived by a beneficiary, all death benefits will be paid in equal shares to the first surviving class of persons listed:

- Your spouse;
- Your children;
- Your parents;
- Your brothers and sisters; or
- Your estate.

CHANGING YOUR BENEFICIARY

You can name, add, or change beneficiaries by completing and signing a **Change of Beneficiary** form available from Human Resource and Risk Services. The change becomes effective when the change form has been received by Human Resource and Risk Services.

PAYMENT OF BENEFIT

Payment of benefits will be made automatically into a personalized, interest-bearing checking account. A checkbook is issued and the beneficiary is free to use it as he or she would any other checking account. There are no maintenance or service fees, no per check charges and no redemption fees or withdrawal penalties.

COVERAGE AT AGE 70 AND BEYOND

When you reach age 70, and are still eligible for Basic Life and AD&D as an active eligible employee, your benefit will be reduced to 65% of the amount to which you would otherwise be entitled, and to 45% of that amount at age 75.

TAX ASPECTS

Current tax laws consider an employer's cost for life insurance coverage in excess of $50,000 as taxable income to employees. If the amount of your basic life insurance results in taxable income to you, the taxable income will be reflected on your year-end W-2 form.

BASIC LIFE INSURANCE COVERAGE

AMOUNT OF BASIC LIFE COVERAGE

The amount of your basic life insurance is determined by your annual scheduled salary, except for regular IATSE-represented and AFSCME-represented Benefitted Temporary Recreation (BTR) employees. Your annual salary does not include bonuses, commissions, overtime pay, or employer contributions to PERS or deferred compensation. Basic life insurance coverage by employee group is outlined in the table below.

LIFE INSURANCE BENEFITS BY EMPLOYEE GROUP

GROUP	AMOUNT	MAXIMUM BENEFIT
AFSCME Regular and Limited Duration Employees	One times your annual salary rounded to the nearest $1,000 (Minimum of $25,000)	$250,000
AFSCME BTR Employees	$25,000	$25,000
EPEA	Two times your annual salary rounded to the nearest $1,000	$120,000
Non-Represented	One times your annual salary rounded to the nearest $1,000 (Minimum of $25,000)	$250,000
IAFF	One times your annual salary rounded to the nearest $1,000	$80,000
IATSE	$25,000	$25,000

COVERAGE AT DISABILITY

You are considered totally disabled if you are unable, due to illness, or accidental injury or pregnancy, to perform the material duties of any occupation for which you are reasonably fitted through your education, training, or experience. Medical certification of disability by Standard Insurance Company is required.

The amount of your continued life insurance will be the benefit that is in effect on the date you become totally disabled. Your life insurance benefits will be subject to age reductions, if applicable, and will be reduced by any Accelerated Benefit you receive.

If you become totally disabled while covered under this life insurance plan and are under age 60, your life insurance will be continued until the earliest of the following dates:

- The date you cease to be Totally Disabled;
- 90 days after the date Standard Insurance Company mails you a request for additional Proof of Loss, if it is not provided;
- The date you fail to attend an examination or cooperate with the examiner;
- The date you reach age 65;
- The date your insurance is converted to an individual life insurance policy; and
- The date the Group Policy terminates.

If you become totally disabled on or after age 60, the length of your coverage will be determined by the terms of the life insurance policy.

CONVERTING YOUR COVERAGE

You may be eligible to convert your basic life insurance coverage to an individual policy if your coverage ends because:

- You are no longer actively at work;
- Your employment with the City of Eugene terminates;
- Your continued life insurance during total disability ends;
- You are no longer a regular employee; or
- The amount of your basic life insurance is reduced.

You must apply for your conversion policy and start paying premiums within 31 days after your basic life insurance stops. You will not have to provide proof of good health. Standard Insurance Company or Human Resource and Risk Services can provide you with the necessary conversion form.

AMOUNT OF CONVERSION COVERAGE

If your life insurance ends because you are no longer actively at work or your employment with the City of Eugene terminates, you may convert up to the amount of your basic life insurance benefit.

If you die during the conversion period, Standard Insurance Company will pay a death benefit equal to the maximum amount of life insurance you had a right to convert, whether or not you applied for an individual policy.

ACCELERATED BENEFITS

The City of Eugene's life insurance through Standard Insurance Company includes an Accelerated Benefit enhancement. This benefit will allow you to receive up to 75% of your Life Insurance benefit early under certain conditions.

To qualify for this benefit, you must:

- Be diagnosed as being terminally ill with a life expectancy of less than 12 months;
- Apply and qualify for Continued Life Insurance; and
- Have at least $10,000 of life insurance in effect.

If your application for Accelerated Benefits is approved by Standard Insurance Company, you are allowed to receive up to 75% of your available Life Insurance benefit. The minimum Accelerated Benefit is $5,000 or 10% of your Life Insurance, whichever is greater. These funds could be used in defraying the cost of special medical treatment, family needs, etc.

Your Group Life Insurance Certificate contains all of the terms and conditions of the Accelerated Benefit. If you have any questions on this benefit, please contact Human Resource and Risk Services.

SPECIAL COVERAGE FOR POLICE OFFICERS AND FIRE FIGHTERS

State of Oregon Mandated Life Insurance Coverage (ORS 243.005)

All police officers and fire fighters receive $10,000 life insurance coverage mandated by Oregon law (ORS 243.005). The $10,000 statutory coverage is included as part of the total life insurance benefit available to police and fire fighters while they are actively employed. **Volunteer police, reserve officers, civil deputies, and clerical personnel are not eligible to receive this coverage.** The $10,000 statutory life insurance is not convertible.

Benefits will be paid only if:

- Death results from an injury sustained during working hours as a police officer or firefighter; or
- Death occurs within 365 days after the date of the injury.

State of Oregon Public Safety Memorial Fund (ORS 243.950)

The Public Safety Memorial Fund provides benefits to family members of Oregon's public safety officers who are killed or permanently disabled in the line of duty. Police officers (including reserve officers) and fire service professionals are considered public safety officers under the statute. The statute defines "family member" as: spouse; child; and, a person who qualifies as a dependent for state income tax purposes.

Benefits include a death benefit of $25,000 to an eligible beneficiary of a public safety officer, as well as health and dental insurance benefits. Other benefits such as educational scholarships and mortgage payments may also be available. (This benefit is not underwritten by Standard Insurance Company.)

Federal Public Safety Officers' Benefits

The Public Safety Officer's Benefits (PSOB) Act provides a $100,000 benefit to eligible survivors of a public safety officer whose death is the direct and proximate result of a traumatic injury sustained in the line of duty. (Each October 1st, the benefit is adjusted by the percentage of change in the Consumer Price Index.)

The PSOB also provides the same benefit to a public safety officer who has been permanently and totally disabled as the direct result of a catastrophic personal injury sustained in the line of duty. To qualify, the injury must permanently prevent the officer from performing any gainful work. (This benefit is not underwritten by Standard Insurance Company.)

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

AMOUNT OF COVERAGE

Depending on the type of loss you suffer, the amount of your Accidental Death and Dismemberment (AD&D) benefit is either the equal to the Full Amount, or one-half the Full Amount. The loss must occur within 365 days after the date of the accident, be caused solely and directly by the accident, and occur independently of all other causes. The tables below list the maximums by employee group and the amount of AD&D coverage.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS BY EMPLOYEE GROUP

GROUP	AMOUNT	MAXIMUM BENEFIT
AFSCME Regular and Limited Duration Employees	One times your annual salary rounded to the nearest $1,000 (Minimum of $25,000)	$250,000
AFSCME BTR Employees	$25,000	$25,000
EPEA	Two times your annual salary rounded to the nearest $1,000	$120,000
Non-Represented	One times your annual salary rounded to the nearest $1,000 (Minimum of $25,000)	$250,000
IAFF	One times your annual salary rounded to the nearest $1,000	$80,000
IATSE	$25,000	$25,000

AMOUNT OF AD&D COVERAGE

TYPE OF LOSS	BENEFIT COVERAGE AMOUNT
Life	Full Amount
Both Hands	Full Amount
Both Feet	Full Amount
Sight of Both Eyes	Full Amount
1 Hand; 1 Foot	Full Amount
1 Hand; Sight of 1 Eye	Full Amount
1 Foot; Sight of 1 Eye	Full Amount
1 Hand	½ Full Amount
1 Foot	½ Full Amount
Sight of 1 Eye	½ Full Amount

Loss of hands and feet means permanent severance at or above the wrist or ankle. Loss of sight means total and permanent blindness. The maximum amount of AD&D benefit which Standard Insurance Company will cover for all losses will not exceed the Full Amount.

WHO RECEIVES AD&D BENEFITS

You receive AD&D benefits if you are seriously injured in an accident and have a loss, as described above. Your beneficiary will receive AD&D benefits if you die in an accident.

SEAT BELT BENEFIT

The Seat Belt benefit matches the accidental death benefit up to a maximum of $50,000. This benefit is payable for death resulting from an automobile accident while you were wearing a seat belt. A copy of the police report must show that an approved seat belt (per National Highway Traffic Safety Council) was in use at the time of the accident.

WHAT IS NOT COVERED

AD&D will not cover losses caused or contributed to by any of the following:

- Insurrection, war or act of war, whether declared or undeclared;
- Suicide or any other intentionally self-inflicted injury, while sane or insane;
- Committing or attempting to commit an assault or a felony or your active participation in a violent disorder or riot (except while performing your official duties);
- The voluntary use of any poison, chemical compound or drug (including prescribed medications), unless used or consumed in accordance with the directions of a physician;
- Any illness or pregnancy existing at the time of the accident;
- Heart attack or stroke; or
- Medical or surgical treatment for any of the above.

SUPPLEMENTAL LIFE INSURANCE

The City of Eugene also offers an optional life insurance program called Portable Term Supplemental Life Insurance. This plan, provided through ReliaStar Life Insurance Company, is voluntary and the premiums are paid by the employee through payroll deductions.

ELIGIBILITY

All regular, Limited Duration and AFSCME-represented Benefitted Temporary Recreation employees are eligible to apply for Portable Term Supplemental Life Insurance coverage. You can apply for coverage during your first 30 days of employment, or during open application periods held twice each year.

Guaranteed Issue Coverage Amount: Within the first 30-day of employment, you can apply for an amount equal to one-times your annual salary (to a maximum of $50,000) without completing a Proof of Good Health form or having your application reviewed by ReliaStar Underwriting.

EFFECTIVE DATE

For "Guaranteed Issue" applications, coverage is effective the first of the month after HRRS receives the application. For all other applications, insurance will become effective on the first of the month after ReliaStar approves your application. Approval of coverage is subject to satisfactory answers to several health-related questions.

AMOUNT OF COVERAGE

Insurance is available for you and/or your spouse or domestic partner from $20,000 to $500,000 in $10,000 increments. Coverage for your spouse is independent from yours but with the same benefits and rates. Children's coverage is also available as a rider, in amounts of $5,000, $7,500, and $10,000.

Accidental Death and Dismemberment (AD&D) is also an option. This allows your beneficiary to collect twice the amount of your policy to a maximum of $250,000 in the event that death was a result of an accident.

OTHER FEATURES

- **An Accelerated Life benefit** is included under Portable Life. This allows you to collect 50% of your policy up to a maximum of $50,000 if you have been diagnosed with a terminal illness.

- **An Accidental Death and Dismemberment (AD&D) benefit** is an available option under Portable Life. This allows you to collect twice the amount of your policy to a maximum of $250,000 in the event that death was the result of an accident.
- **Portability** – If an employee terminates employment or retires, Portable Term Life coverage may be continued by remitting premiums plus an administration fee directly to ReliaStar Insurance Company. Contact HRRS for more information, and to obtain a ReliaStar Supplemental Life Coverage Continuation Request form.

COST

The employee pays the entire cost of the insurance. The premiums are deducted from your paycheck. Premium rates depend on your age and the amount of insurance you purchase. A current premium schedule is available from HRRS.